PM/2 for Windows

User's Manual

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PM/2 for Windows: an overview

PM/2 for Windows is a billing and clinical record-keeping system for mental health professionals. Designed to run under Microsoft Windows XP, NT, 2000, Me and 98, and written in the CA-Visual Objects language, it is built around a central Patient Database which contains extensive demographic information about each patient in your practice. The patient database is linked to a Financial Database which presents each patient's account record in a tabular format organized toward the requirements of a managed care environment (risk pool withholds, tiered copayments, etc.) Visits, payments, adjustments, etc. are posted directly to this account record, and bills and insurance claims are produced from it by single mouse clicks. In addition, automatic links are provided to supporting databases which contain

- DSM-4 and ICD-9 diagnostic data
- CPT-4 procedural coding data.
- Insurance coverage, guarantor and responsible party data
- Referral source, place of service and treating clinician data
- Copayment, deductible and managed care data

Clinical options provide facilities for

- clinical notes
- appointment scheduling
- prescription writing and logging
- lab result tracking

Additional features provide for production of mailing labels and related stationery items; backing up and restoring data to and from diskettes; and extensive printed reports from many windows. Complete DDE functionality (Direct Data Exchange) enables data to be shared with all other Windows applications, and the Clipboard facilitates

transfer of formatted text from your favorite Windows-based word processor.

Hardware requirements

PM/2 for Windows requires a Pentium-166 or faster PC, equipped with a minimum of 32 MB of RAM. Approximately 50 MB of free hard disk space is also required.

Microsoft Windows 98 or Windows 95 is required. PM/2 for Windows can run on any video display and printer which is supported by Windows.

Please note that ***PM/2 for Windows*** can run on computers which do not meet the above minimum specifications, but performance may be too slow for satisfactory results. The same applies to Windows emulation products for the Apple Macintosh computer.

Installing PM/2 for Windows on your computer

To install PM/2 for Windows, just open the sealed envelope and insert the CD-ROM into the CD or DVD drive of your computer. The Setup program will normally start by itself. If it does not, click the My Computer icon at the upper left hand corner of your screen, then click the icon for your CD drive and then the Setup icon to begin the installation process.

Importing data from *PM/2 for DOS*

If you are a user of the DOS version of PM/2, you can readily import your data into PM/2 for Windows. This can be done without endangering or modifying your existing PM/2 for DOS data in any way. The only requirement is that the DOS data set must be present on the same computer where you are running PM/2 for Windows; that is, you cannot run the import routine from a diskette backup of PM/2 for DOS.

To run the import utility, just click the menu options: Utilities, Import, Import from PM/2 for DOS. The dialog box will ask you where your DOS data files are located, and will prompt you with the default location, which is C:\MGR. If your data are in some other drive and/or folder, make the necessary changes on this window and click OK. The remainder of the import procedure is fully automatic and requires no operator intervention.

Please carefully check over your data after the import procedure. The import routine assumes that you have stored your DOS data in completely standard style, so that it may be confused by such things as missing commas or non-standard state abbreviations in address lines. These items may require manual correction.

Please also be aware of the limitations of the import routine. It does not bring in the following categories of data: (1) managed care approvals; (2) laboratory results; and (3) appointment calendars.

Importing data from *Shrink for DOS*

If you are a user of any DOS version of the "Shrink" program (a product and trademark of MultiHealth Systems, Inc.), you can also readily import your data into PM/2 for Windows. This can be done without endangering or

modifying your existing "Shrink" data in any way. The only requirement is that the DOS data set must be present on the same computer where you are running PM/2 for Windows; that is, you cannot run the import routine from a diskette backup of the "Shrink" product.

Before running the import utility, please copy the file INSULIS2.FMT from the C:\PM2W folder to your Shrink data folder. Then, you will need to run the following 5 "Shrink" reports to disk (NOT printer), as shown below. Use the system defaults when no fill-in instructions are provided for a given field:

- The insurance carrier list: Select Reports, Report Query. Under Database File, press F2 and select 2, Insurance. Under Template, press F2 and select INSULIS2. Under Output, press F2 and select 6, File. Under File, type in INSULIS2 and press F10.
- The practice ID: Select Setup, Practice Setup, Practitioner, Reports, Prac. ID. Under Output, press F2 and select 6, File. Under File, type in PRACID and press F10.
- The patient file: select Patient, Reports, Profile Report, Account. Under Output, press F2 and select 6, File. Under File, type in PATPROF and press F10.
- The service codes list: select Setup, Practice Setup, Service Code, Reports, Service Code. Under Output, press F2 and select 6, File. Under File, type in SVCLIST and press F10.
- The patient accounts file: select Reports, Individual Account Ledger, By Patient. Change the "From" date to 01/01/80. Under Output, press F2 and select 6, File. Under File, type in PATACCT and press F10.

It is very important to use the exact file names as specified above, because these are the names under which PM/2 will look for the required files. These names are hard-coded into the import utility, so no spelling variations are permissible.

After completing the 5 "Shrink" reports listed above, close "Shrink" and start PM/2 for Windows. Click the following PM/2 menu options: Utilities, Import, Import from Shrink for DOS. The dialog box will ask you where your DOS data files are located, and will prompt you with a default location of C:\SHRINK3. It will be necessary to modify this default because "Shrink" data tend to be located in a subdirectory of the program folder, e.g., C:\SHRINK3\DATA. Select the appropriate subfolder and click OK. The remainder of the import procedure is fully automatic and requires no operator intervention.

Please carefully check over your data after the import procedure. There should be complete agreement between results produced by the two systems because the data source for the import is the output produced by the "Shrink" program; however, results can be affected by various factors.

Treatment Planning in *PM/2 for Windows*

PM/2 for Windows offers an optional Treatment Planning module, known as ***PM/2 Clinical Planner. PM/2 Clinical Planner*** can be run as a separate, free-standing program, or you can click the Treatment Planning option on the Clinical menu of ***PM/2 for Windows***, and ***Clinical Planner*** will be launched automatically, pre-loaded with the demographic and diagnostic data on your patient taken from ***PM/2 for Windows***.

PM/2 for Windows users who did not purchase the treatment planning option originally, may do so at any time by ordering it directly from PM/2 Software, Inc., at 1-800-874-2159.

On-line help

An extensive on-line Help system can be accessed, either by clicking the Help menu on the menu bar, by clicking the button located on most windows, or by pressing the F1 key on your keyboard.

Basic operations and work flow

After installing ***PM/2 for Windows***, you need to enter some basic information into the system.

1) **Who are you?** Tell ***PM/2 for Windows*** about your practice by filling in the User Identification window (the first menu item under Files). Also enter the biographical details for each provider in your practice (even if there is only one) by filling in a Provider Roster window for each provider. Note that you can enter a new provider by clicking the Insert icon on the Provider roster browse window; this icon is used throughout PM/2 for Windows to signify entering a new record into any file. You should also complete the Insurance Carrier and Referral Sources browse windows at this time. Click **OK** to complete any entry.

2) **Who are your patients?** Click Patients under the Files menu; a blank Patient Selection window will come up (unless you have imported your data from ***PM/2 for DOS)***. Click the Insert icon as described above, to enter each patient into the system. Note that the Patient Information series of windows is quite long; you do not have to go through every single window in order to complete the patient registration; you can always come back and fill in missing details later on.

3) **What visits and payments have taken place?** See the sections below on Posting Visits and Payments and on

writing Progress Notes, Prescriptions and logging Lab Results for the details on day-to-day entry of these items.

The above triad of data items—the practice, the patients, and the posting—comprises the work flow under ***PM/2 for Windows.*** All the rest is commentary; go and study it!

Tutorials

The following sections consist of 12 detailed tutorials, designed to help you get started with PM/2 for Windows. A 13th tutorial points the way to advanced topics covered in the alphabetical reference section of this book.

Tutorial 1: Identifying yourself to the system

Learning goals for this tutorial:

- Learn how to make menu selections in PM/2 for Windows.
- Learn how to fill out a simple data-entry window.
- Inform PM/2 for Windows who is the licensee of this copy of software and who are the provider(s) in this practice.

Step 1: Identify the menu bar that goes across the top of your screen, underneath the band identifying PM/2 for Windows as the program that you are running. Notice the options: File, Edit, Billing, Insurance, etc. We're going to look at the File menu. This is where PM/2 for Windows, like most Windows applications, groups all of its functions for entering and reviewing data.

Step 2: Click File on the menu bar. This will pull down the File Menu, displaying the options User Identification, Patients, Financials, etc. Notice that you can activate a menu bar option by clicking on it with the left mouse button, or by holding down the Alt key on the keyboard plus the underlined letter of the desired option (in this case, F).

Step 3: Click User Identification on the File menu. This will bring up the User Identification window. Notice that you can activate a menu option by left-clicking it with your mouse, or by pressing the underlined letter of the desired option; or you can jump to it directly, without activating the

menu, by pressing the indicated accelerator-key or key combination (in this case, the F2 key).

Step 4: Examine the User Identification window. Notice that it has three parts:

- A toolbar. This is a series of pictorial "icons" just under the title bar of the window. These provide alternatives to certain menu options. We're going to ignore the toolbar in this particular tutorial.
- A set of data-entry fields. These are spaces into which information can be typed, checked off, or selected from pre-determined lists.
- Two "action buttons," marked OK and Cancel. These buttons have essentially the same meaning in all Windows applications: click OK to save data, Cancel to discard it.

Step 5: Type in the name, address, etc. of the practice. This may be simply the name, degree and office location of the professional owner (e.g., John Wingate Doe, MD, PhD). Or it may be a business name (e.g., "Park East Clinic") even if Dr. Doe is the sole practitioner in the clinic. If two or more professionals are sharing the software in a loose arrangement that does not constitute a formal group practice, you can enter something like "Drs. Green and Brown" or "Green, Brown, Redd et al." The names and details of the individual providers will be entered later. Enter as much of the information called for on this window as possible; leave blank any fields that do not apply.

Step 6: Click OK when you are completely satisfied with the contents of the field, click the OK button in the lower right-hand corner. If you wish to discard the data you have entered and keep the window in its initial condition, click the Cancel button. But you will have to save this information at some point before going on to the next step.

Step 7: After clicking OK, read the message box and make

a decision. If you are setting up the software for a solo practitioner and have entered just the practitioner's name, professional details and address, click OK to put this same information in the Provider Roster. At this point you will have finished this tutorial. On the other hand, you may be setting up a multiprovider office, or you may be setting up for a sole practitioner but the practice name may not be the same as the professional's name. In this case, click Cancel and go on to the next step.

Step 8: Click File on the menu bar, then Provider Roster, and then the Insert toolbar button. This will bring up the Add New Provider window of the provider roster. Complete and save this window for each professional in the practice. Notice that this window is identical to the User Identification window, with the exception of one extra data field: each provider must be designated as either billing under his or her own name and tax ID number, or that of the practice (if any). It is possible to have different providers with different billing arrangements, or even multiple entries for the same provider if some of their work is billed individually (e.g., Dr. Smith [1]) and some on behalf of a group entity (e.g., Dr. Smith [2]).

Review: In this tutorial we have seen how to make menu selections and how to fill out a simple data-entry form. We have also saved information about the software licensee (the User Identification window) and about the professional service provider(s) (the Provider Roster), who may or may not be the same person(s).

Tutorial 2: Entering your insurance carriers

Learning goals for this tutorial:

- Learn to use toolbar buttons and accelerator keys.
- Increase your skill at data entry.
- Get your insurance carriers on board.

In this lesson, we are going to get your insurance carriers (or a few of them, at least) into the system while simultaneously helping you to use the ever-present toolbar buttons and menus of PM/2 for Windows.

Step 1: Click File on the menu bar, and then Insurance Carriers on the File Menu. Notice how the (empty) insurance carrier window comes up. Don't enter any data yet. Instead, close it by clicking Cancel or by clicking the little "X" in the upper right hand corner of the window. Notice how both methods have the identical effect.

Step 2: Once the window is gone from the screen, press F9. Magic, huh? Not really. F9 is the accelerator key on the File menu for Insurance Carriers. Close the window, pull down the file menu again and check it out. Notice that accelerator keys do not work when any pull-down menus are visible. Click Insurance Carriers again to reopen the Insurance Carriers browse window.

Step 3: Now we're getting ready to enter some data. But let's check out 3 alternate ways of doing so first:

- Click Edit on the menu bar, then Insert Record. Notice the "Add new insurance carrier" form that comes up. Don't do anything with it yet; click Cancel to get rid of it.
- Look at the toolbar on the insurance carrier browse window. See the little blue button that looks like a dog-eared square of paper? It means "Insert" and has the exact same effect as the Edit, Insert menu options (and

it only takes one mouse click, on a larger target, instead of two). Again, close the Add New Insurance Carrier window without saving any new data.

- Click Edit, Insert Record again. Notice the accelerator key on the menu option? It is Insert, which signifies the Ins key on your keyboard. So press Esc, or click your mouse somewhere on the desktop, to get rid of the Edit menu, and try pressing the Ins key to bring up the Add New Insurance Carrier window. This time, leave it open. You can use whichever of these three methods you prefer for opening the Add New Data window of any of the data browsers in PM/2 for Windows.

Step 4: Now type in the name and details for one of your insurance carriers. Only the carrier name is obligatory, but try to enter as much information as you have available about each carrier. Notice the field "carrier type" in the upper right hand corner of the window. This information is necessary for proper completion of Box 1 of the HCFA-1500 form, and for proper routing of electronic claims. It is not sufficient to enter the name of a carrier, because PM/2 has no way of determining from the name alone whether a given carrier is a commercial insurance plan, a Blue Cross plan, a medicare intermediary, or whatever.

Step 5: Click OK when you are satisfied with the new carrier information. Notice how it is immediately transferred to the table of insurance carriers in the browser.

Step 6: Identify the Delete toolbar button on the browser: it looks like a trash can, and is used for deleting items on all the data browsers throughout PM/2 for Windows. Highlight one of your insurance carriers, and click it. If you change your mind, you can respond No on the "Do you really want to delete this item?" box.

Tutorial 3: Entering your service locations

Learning goals for this tutorial:

- Reinforce the skills acquired in the previous tutorial
- Get your service locations on board

In this lesson, we are going to get your service locations into the system while reinforcing the skills acquired in the previous tutorial. Service Locations are the places where the professionals in your practice work: e.g., office, hospital, school, nursing home, patient's homes, day treatment programs, etc. Since billing may be different for each of these sites, each site must be defined for the system.

Step 1: Click File on the menu bar, and then Service Locations on the File Menu. This brings up the (empty) Service Locations browse window.

Step 2: Look at the toolbar on the browse window, identify the little blue "Insert" button, and click it to bring up the Add New Service Location window.

Step 3: Now type in the name and details for one of your service locations.

Step 4: Click OK when you are satisfied with the new location carrier information. Notice how it is immediately transferred to the table of locations in the browser. Repeat the process for as many sites as you have in the practice.

Tutorial 4: Entering your referral sources

Learning goals for this tutorial:

- Reinforce the skills acquired in the previous tutorial
- Get your referral sources on board

In this lesson, we are going to get your referral sources into the system while making you an expert in adding data to a browse window in PM/2 for Windows. It is important to have a file of referral sources in PM/2 both for marketing purposes (the system enables you to track earnings derived from each source of referrals) and for proper completion of insurance claim forms (claims for consultative services, filed with Medicare and some other carriers, require identification of the referral source for regulatory reasons).

Step 1: Click File on the menu bar, and then Referral Sources the File Menu. This brings up the (empty) Referral Sources browse window.

Step 2: Look at the toolbar on the browse window, identify the little blue "Insert" button, and click it to bring up the Add New Referral Source window.

Step 3: Now type in the name and details for one of your referral sources.

Step 4: Click OK when you are satisfied with the new referral source information. Notice how it is immediately transferred to the table of referral sources in the browser. Repeat the process for as many referral sources as you can identify for your practice. This list, like all the others, can be added to over the course of time as additional sources are identified.

Tutorial 5: Registering a new patient

Learning goals for this tutorial:

- Learn how to access and update the patient data base
- Get a few (real or imaginary) patients into the system

Now that we've got the ancillary databases (service locations, referral sources, providers and insurers) set up, we're ready to enter our first patients into the system. For purposes of this tutorial, you can use either real or imaginary patients.

Click File on the menu bar, and then Patients. This brings up the Patient Selection window.

Notice the (empty) table of patient names, addresses etc., as well as the "Patient last name" field at the top. Once you have entered one or more patients into the system, these two parts of the window will provide you with methods for calling up patient records.

Notice also the OK, Cancel, Help, and Register New Patient buttons at the right. These are "
action buttons," which we've already seen on the browse windows. Since you do not yet have any patients in the system, you'll want to click Register New Patient. This brings up the multi-part Patient Demographics window.

Notice the tabs along the top of the Patient Demographics window, but don't click any of them yet. You must first fill in the basics on Demographics I before wandering through the tabs to fill in other information as needed.

Each of the tabs on the Patient Demographics window has its own detailed Help screen, which is activated by clicking the Help button at the right. Read each Help screen to clarify specific issues with each tab.

At this stage, we'll focus on just 3 of the many tabs on this window: Demographics I, Insured Party I, and Copay/deductible.

Demographics I: there is nothing challenging here, just patient name, address and telephone number-type information. Fill in (or make up, if you are using fictitious data for practice purposes) as much as you can, then click OK. You'll return to the Patient Selection window, but now you'll see the name of your first patient in the browse section of the window! To fill in further details on this patient, click the OK button (rather than the Register New Patient button), because you're now updating the record on an "established" patient!

Insured party I: This refers to the person who holds the insurance, if any, for the patient named in Demographics I. If the insured party is the same as the patient, just click the Self button under "Patient Relationship to Insured" and all of the identifying information will be transferred in from Demographics I.

There are two other critical fields on this window: the Insurance Carrier field and the Insurance ID no. field. Notice the down-arrow at the right of the Insurance Carrier field. This pulls down a scrollable list of all of the insurance carriers you previously entered in the Insurance Carrier browse window. Select one (even if fictitious); it can always be changed later. Then type in the insurance ID no. that applies to the patient for this carrier. Don't click OK yet, because we're going on another tab of this window.

Copay/deductible: This is where we enter the critical information about who is responsible for the patient's charges. The system recognizes five different models of copayment responsibility, as shown on the window:

- Self-pay: there is no insurance, patient responsible for everything.

- Level copayments based on a flat dollar amount.
- Level copayments based on a percentage of the fee.
- Tiered copayments based on the type of service (e.g., consultations covered at one rate, psychotherapy covered at another rate, medication management covered at yet another).
- Tiered copayments based on duration of treatment (e.g., first visit covered at one rater, next 5 visits at a lower rater, remaining visits at yet a lower rate).

For demonstration purposes, let's stay with one of the simpler models, i.e. self-pay or level copayment.

Before leaving this window, if any model other than self-pay has been selected, make absolutely certain that you have entered the correct effective date of coverage for this insurance. Also notice the "dollar cap" field: by default, it is set to a fictitious, very high level. Do not reset this amount unless you know the dollar amount where the patient's coverage "
maxes out:" users sometimes reset this value to zero because $99,999.99 looks too high, and by doing so inadvertently tell the computer that the patient is already out of insurance coverage.

When you're done with all three of these fields, you can now click the OK button to save the data on this patient. Review it and make any desired changes, clicking the OK button when you are done.

To select a patient on the Patient Selection window when more than one patient has been entered into the system, you have two choices:

- Enter the first few letters of the patient's last name in the field provided
- Scroll the table, moving the highlight until you're on the desired name

Whichever method you choose, click OK or press Enter to signify your selection.

Notice also the trashcan icon on the Patient Selection Window toolbar. You can use it to delete a record entered erroneously or for practice.

Tutorial 6: Posting a visit

Learning goals for this tutorial:

- Learn how to access and review the Patient Account Record
- Learn how to post a visit via the Patient Account Record.

There are several methods for posting visits in PM/2 for Windows. We're going to focus on just one of them in this tutorial: the Patient Account Record.

Click File on the menu bar. This brings up the File Menu. On the File Menu, click Financials, which brings up the Financials sub-menu. On the Financials menu, click Patient Account Record, and select one of the patients entered on the previous tutorial. This brings up the (blank) patient account record.

Notice the row of toolbar buttons at the top of the Patient Account Record window. These are your Posting Buttons. Click the Vis button to post a visit. This brings up the Visit Posting window. In a real-life situation, where you have filled in all of the information on the patient database tabs, almost everything here will have already been filled in for you from system defaults; but for learning purposes, let's go over the content of this important window, field by field:

- Date of service: not necessarily the same as the date of posting which is the default. Correct this if necessary.
- CPT4 code: the service code for the visit you are posting. Will default to the primary Fee Override code on Demographics 4, if any.
- Treating clinician: will default to the provider named in Demographics I for this patient.
- Place of service: will default to the usual place of service named in Demographics III.

- Primary diagnosis: will default to primary diagnosis shown on the DSM tab, if any.
- Fee: standard: will default to the override fee on Demographics IV, if any; or to the default fee for this patient's insurance coverage for the service selected under CPT4 code on this window, if there is no override. If the fee schedule is blank, then this field will be initially blank as well. Enter the applicable fee for this service.
- Fee: discounted: if you are billing at a "nominal" rate of, say, $100.00 for a given service, but you know that this patient's managed care or Medicare coverage will reduce the fee to some maximum "allowable" level, say $86.23, enter that amount here.
- Copayment: will pop in automatically if you have entered a copayment rule on copay/deductibles. In the case of self-pay patients, all three of these fee fields are identical. Copay is 100%, not 0%, in the self-pay case.
- Rec'd today: If the copay is, say, $10.00 and the patient has paid exactly that amount today, click this box (it saves having to enter the payment separately).
- Remarks: narrative text (account-related) of your choosing.

Click OK when satisfied with this data, or Cancel to abandon it and start over.

Note that any line on the patient account record can be deleted if entered in error, by highlighting it and clicking the trashcan toolbar icon. Use great care in changing numbers on the account record table, as careless changes may put accounts out of balance and be difficult to correct.

Tutorial 7: Posting a payment

Learning goal for this tutorial:

- Learn how to post a payment to the Patient Account Record.

Click File on the menu bar. This brings up the File Menu. On the File Menu, click Financials, which brings up the Financials sub-menu. On the Financials menu, click Patient Account Record, and select one of the patients entered on the previous tutorial. This brings up the (blank) patient account record.

Again, notice the row of Posting Buttons in the toolbar at the top of the Patient Account Record window. Click the Pay button to post a visit. This brings up the Payment Application Window.

The first four items on this window are largely self-explanatory: date, amount, check no. and description of type of payment. Fill these in for the item you are about to post.

Now think about how this payment item should be applied. Should it be applied, like cash, to the oldest outstanding balance first? Or is it, for example, an insurance check, which must be earmarked to specific visits? Choose "oldest outstanding balance" or "I'll specify", as the case may be.

Then indicate the source of payment: from patient, primary or secondary insurance? Note that the system considers all non-insurance payments, even if from parents, friends, etc. to be "patient payments."

If you have specified "oldest outstanding balances", you are done with this window now, and you can click OK if you are satisfied with the data. On the other hand, if you've clicked "I'll specify," you now have to do just that.

Look at the table of open visits in the lower half of the window. It shows all the visits for which some balance remains outstanding at this time. In the yellow-highlighted column, take the total Amount Paid from the top of the window, and divide it up as necessary. The only restriction is that the various amounts you enter into the table, e.g., $5 to one visit, $10 to a second visit and $15 to a third visit, must equal the total Amount Paid at the top (in this example, $30).

Click OK when you're satisfied with the data, or Cancel to abandon it and start over.

Tutorial 8: Running a patient statement

Learning goal for this tutorial:

- Learn how to run off a patient bill in PM/2 for Windows.
- Learn how to use the Report Destination window to preview, print and file reports.

Once you have entered the Patient Demographic data and the visit and payment data in the previous tutorials, running off a patient statement (bill) is a snap. Just click Billing on the menu bar, then Run Single Statement on the billing menu (or use the Shift + F2 accelerator key combination) and select the patient for whom you want to generate a statement. On the Run Statement window, the opening and closing dates of the statement period will appear. These dates default to the first and last days of last month, as determined by the computer's internal clock, and may have to be adjusted so that they include the dates of the sample data you have entered in the previous tutorials. When you have the dates in place, click OK to bring up the Report Destination window.

The Report Destination window gives you five options as to where your printout should go. We'll only look at the first two in this tutorial: you can Print the report immediately, or you can Preview it on screen and then print it if is satisfactory. The remaining options are for users wishing to save the printout to disk for later printing, and for customization of the printout format, an advanced topic.

Print out your sample statement, either from the Report Destination window or from the preview window, to complete this tutorial.

Note that you can also print out a whole run of statements, rather than just a single one as we have done above, by selecting Run Multiple Statements rather than Run Single Statement on the billing menu. The Run Multiple

Statements window has a detailed help screen of its own, to show you the various kinds of statement runs that are available; please read it at your leisure.

Tutorial 9: Running a HCFA-1500 insurance claim form

Learning goal for this tutorial:

- Learn how to run off an insurance claim form in PM/2 for Windows.
- Review the use of the Report Destination window in previewing, printing and filing reports.

Running off claim forms is very similar to running off bills, covered in the previous tutorial. Once you have entered the Patient Demographic data and the visit and payment data, click Insurance on the menu bar, then Run Single Claim on the Insurance menu (or use the Shift + F5 accelerator key combination) and select the patient for whom you want to generate a claim form. On the Run Insurance Claim window, the opening and closing dates of the claim period will appear. These dates default to the first and last days of last month, as determined by the computer's internal clock, and may have to be adjusted so that they include the dates of the sample data you have entered in the previous tutorials. When you have the dates in place, click OK to bring up the Report Destination window.

Depending on your preferences and local carrier requirements, you can print off the entire form on plain blank paper, or you can print just the contents of the form onto pre-printed blanks. See Appendix E for a detailed discussion of this technical point.

The Report Destination window gives you five options as to where your printout should go. As in the previous tutorial, we'll only look at the first two in this tutorial: you can Print the report immediately, or you can Preview it on screen and then print it if is satisfactory. The remaining options are for users wishing to save the printout to disk for later printing, and for customization of the printout format,

an advanced topic. If you notice that the claim form needs to be re-positioned on the page, you'll need to use the Modify Format option to change your margin settings from their default values.

Print out your sample claim form, either from the Report Destination window or from the preview window, to complete this tutorial.

As with statements, you can also print out a whole run of claim forms, rather than just a single one as we have done above, by selecting Run Multiple Claims rather than Run Single Claim on the Insurance menu. The Run Multiple Claims window has a detailed help screen of its own, to show you the various kinds of statement runs that are available; please read it at your leisure.

Tutorial 10: Running reports

Learning goal for this tutorial:

- Learn how to run off an Aged Accounts Receivable report in PM/2 for Windows.

There are many, many different accounting reports available under the Reports menu of PM/2 for windows. We'll use just one, the Aged Accounts Receivable report, as a teaching tool; the lessons here apply to all of the other reports as well.

Select Reports from the Menu Bar, then Aged Accounts Receivable from the Reports Menu. This brings up the Aged Accounts Receivable box, which is a very simple dialog that just asks you for the as-of date of the report (other reports have both a From and a To date). By default, the report will run as of the end of the previous month, as determined by the system clock. Click OK when you're satisfied with the date.

This brings up a special window for the A/R report: you have the option to prepare the report based on patient balances, insurance balances, or total balances (the default). This allows you to analyze your receivables from several different points of view. Choose your point of view, and then click OK.

This begins the report preparation. Notice the progress bar going across the report window; when it reaches 100%, the now-familiar Report Destination box will come up. Print or preview the report, as you choose.

Tutorial 11: Using the appointment calendar

Learning goal for this tutorial:

- Learn how to run use the Appointment Calendar in PM/2 for Windows for scheduling and posting.

To bring up the appointment calendar, click File on the menu bar, then Appointment Calendar. If more than one provider has been entered into your system, you will be asked to specify which provider's calendar to bring up. Note that the PM/2 for Windows Appointment Calendar displays appointments for a week at a time, seven days per week, for one provider at a time.

When the calendar is first called up, the present week (as determined by the system clock) is displayed. To display an earlier week, click the arrow at the left of the date field; to display a later week, click the arrow at the right of the date. An informational message is received if you try to display an "out-of-range" week.

Appointments and events can be scheduled well into the future. The system is installed with one year's worth of blank calendar "pages," beginning with the week of installation; after six months, and every year thereafter, another year's worth of pages is added so that you can always schedule events at least six months, and usually l2-18 months, into the future.

To print out the current calendar, click either the Print Day or the Print Week button, depending on how much of the calendar you wish to print out.

If a patient calls asking "When is my next appointment?," click the Lookup button. The system will search through the entire database of previously saved appointments until it either finds the next scheduled appointment for this patient, or reaches the end of the file. Either way, the

system will advise you of the outcome in a message box.

If you see a significant number of patients on a regular weekly basis, you will find the calendar's template capability very useful. The template facilitates the entry of standing or recurring weekly appointments, by letting you fill in the calendar for one "typical" week, then click the Save to Template button. The week thus saved becomes a "template" for future weeks, meaning that before you schedule anybody for the future, you can click the Fill from Template button and the standing appointments are filled in on your new calendar page. Only the changes (e.g., patient vacations) need to be entered on the specific week when they occur. Since the template remains the same until it is revised, the regular appointment will show up again on the week following the cancelled appointment.

You can also post the appointments shown on a given calendar page directly to each patient's account by clicking the Post button. This is a convenient alternative for solo practices operating without secretarial help, in which appointment data will typically be posted in weekly or monthly batches, in arrears, rather than on a daily or hourly basis as the patients come in.

The Format button brings up the Calendar Formatting options window, which allows you to select from three sets of formatting options: Appointment Interval (15, 30 or 60 min); Appointment Display Style (1, 2 or 3 lines per entry); and Appointment Range (starting and ending times for your work day). For further details, see Calendar formatting options.

The Done button simply signifies that you are finished with the calendar and wish to save it "as is," much like the OK button on other windows. The Clear button erases all entries on the calendar after giving you a chance to cancel this choice with an "Are you sure?" message box.

Tutorial 12: Writing progress notes

Learning goal for this tutorial:

- Learn how to run write and save Progress Notes in PM/2 for Windows.

PM/2 for Windows has an extensive array of clinical as well as business functions. In this tutorial, we'll focus on just the Progress Notes module.

To start the Progress Notes module, click File, Clinical, Progress Notes, and select the patient on whom you wish to write. If there are not yet any notes on file, please click Yes when the box comes up informing you of this. You should now be on the Write Progress Notes window.

Text may be entered onto this window in a variety of ways:

- Just type it straight text.
- Use the Paste button to bring in text previously placed on the Windows Clipboard. Text can be placed on the clipboard by highlighting it and clicking either the Copy or the Cut button in your word processor or automated dictation program.
- Use the Template button to bring in pre-written document outlines or boilerplate paragraphs that you need in your reports or progress notes.

Click OK to permanently save text into the Progress Notes file. Be careful, because progress notes cannot be deleted once saved.

Once you have saved some content to your Progress Notes file, you can bring it up again by clicking File, Clinical, Progress Notes and browse through it with the << | < | > | >> buttons, signifying first/previous/next/last note respectively. And the little Printer toolbar icon will bring up a window allowing you to print out some or all of your

notes at any time.

Congratulations! You have reached the end of the regular Tutorial. Take a well-earned rest before looking at Advanced Topics, below.

Tutorial 13 Advanced topics

There is a great deal more in PM/2 for Windows. In this final tutorial, we're only going to list some of the additional capacities of the system, and refer you to the appropriate pages of this User's Manual or other documents for further information. In addition, the online Help system and the PM/2 web site (http://www.pm2.com) should be consulted for updated technical information and updates to this documentation.

- **Managed care tracking**: enter the number of sessions allocated by the managed care company, and the system will track visits remaining in the allocation (this Manual, pg. 113)
- **Guarantors other than patient or insured party**: the system can address bills to one or two responsible parties, who can be individuals other than the patient and the insured party (pg. 97)
- **ICD or DSM diagnoses**: you can use either diagnostic system, and add codes to the system at any time.(pg. 85)
- **The Daysheet**: an alternative method of posting, which allows you to enter multiple transactions without bringing up each patient ledger one by one (pg. 80)
- **Prescriptions and Lab Results**: write and record medication prescriptions and record laboratory results where medically relevant (pg. 134)
- **The PM/2 Clinical Planner**: generate full-scale clinical treatment plans with this optional add-on feature of PM/2 for Windows (see the separate PM/2 Clinical Planner User's Manual).
- **Fee schedules**: the system can hold up to ten alternate fee schedules, for use where you have negotiated multiple managed-care contracts or are required by law to charge specified fees for various classes of patients (e.g., Medicare, Medicaid) (this Manual, pg. 93)
- **Alternate statement formats**: The Billing Menu provides a choice between Simple and Detailed

statement formats, depending on your style of practice and taste (pg. 49)

- **Electronic claims capability**: PM/2 for Windows offers optional Electronic Claimis submission capability, for paperless transmission of your claims to clearing houses or end payors (Appendix A).
- **User-designed reports**: If you don't find the report you're looking for in the Reports menu, you can design it yourself with this module (Appendix B).
- **Forms generator**: run mailing labels, face sheets and the like for any subset of patients, referral sources, etc. All popular Avery label formats are supported (pg.)
- **Back up and restore your data** with PKZip compression (pp. 47, 147)
- **Password security** for any number of users, with five different access levels (pg. 119)
- **Import your data** from PM/2 for DOS with a single menu selection. A boon for users of our earlier DOS product (pp. 7-8)
- **Export your patient database to your Palm Pilot** (Appendix C).

PM/2 for Windows: Alphabetical Reference Guide

Accounts receivable report

Purpose: *Run the Aged Accounts Receivable report*
Menu selections: *Reports, Aged accounts receivable*
Accelerator Key: Shift + F10

The aged accounts receivable report shows how much money is outstanding, by patient, according to length of time that the bill has been outstanding.

The report can be run as of any desired date, that is, the as-of date does not have to coincide with month-end or a billing cycle, although it is often convenient to do so.

The report be run in any of three different modes: for patient balances, for insurance balances, or total balances due. Accounts are aged into columns for under 30 days, 31-60 days, 61-90 days, 91-120 days, over 120 days and totals. Here is a sample of how the report looks in the "patient balances" mode:

PM/2 for Windows Accounting Reports

Aged Accounts Receivable Report

Patient balances as of 06/30/97

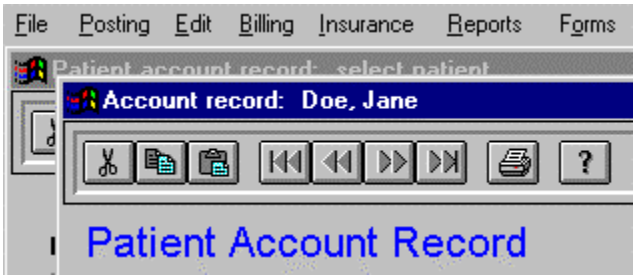
		Days Outstanding:				
t Name	Acct no.	0-30	31-60	61-90	91-120	>120
, CHRISTINA	83604815					-80.00
an, Roy	47100319					-140.00
IK, JONATHAN	44477382				-140.00	180.00
Q, CHRISTINE	38033027					-180.00

Adjustments, posting of

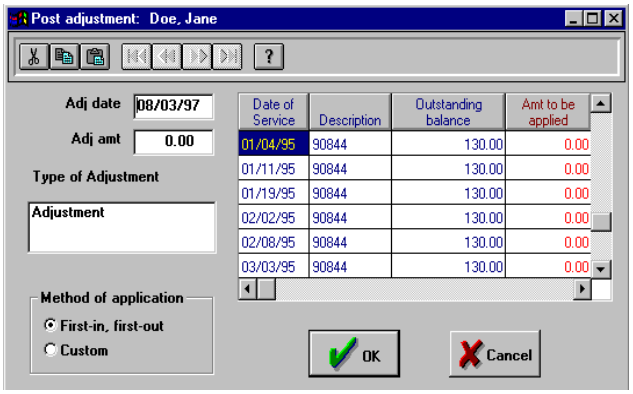
A

Purpose: *Post an adjustment to a patient account*
Menu selections: *Posting, adjustments*
Accelerator Key: *None*

Adjustments can be posted to a patient account whenever the Patient Account Record window is visible, and has focus, on the screen. When the Patient Account Record has focus, the Posting Menu is inserted into the menu bar between the File and Edit menus, as shown below:



The Adjustment Posting window has the following form:



Data entry fields of the Adjustment Window:

Adj date: the as-of date of the adjustment. This does not have to be the same as the date on which you are posting the adjustment.

Adj. amt: the dollar amount to be adjusted off the

patient's account.

Type of adjustment: a scrollable list of all defined Adjustment types appears in this window. Select the type most appropriate for the transaction you are posting.

Method of application: First-in, first-out ("**FIFO"**) application means that dollars adjusted off are applied first to the oldest outstanding balances. "**Custom"** posting means that you will specify how much of the adjustment amount is to be allocated to each open visit in the right hand side of the window. This area of the window is used for custom application instructions for this adjustment. All visits with outstanding balances, and the amounts of such balances, are shown in this part of the window, and you may specify exactly how much of the total adjustment is to be applied to each visit. An error message will be received if the individual application amounts does not add up to the total amount being posted.

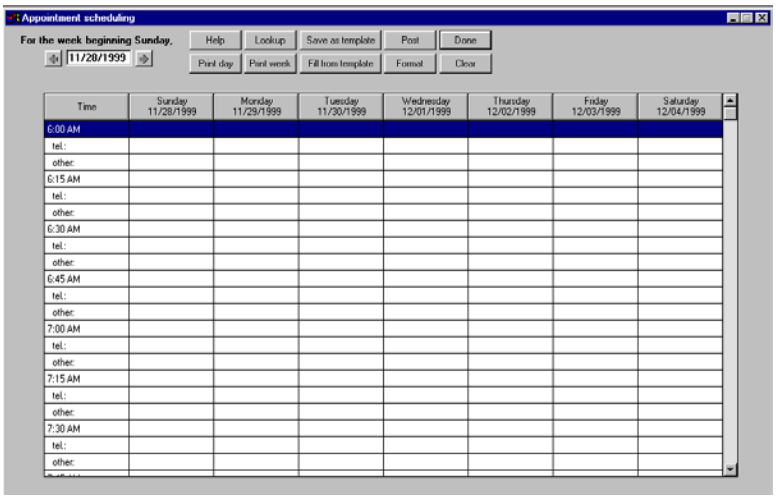
Appointment scheduling

Purpose: *Schedule future patient and other appointments*
Menu selections: *Files, appointment scheduling*
Accelerator Key: *F5*

The ***PM/2 for Windows*** Appointment Calendar displays appointments for a week at a time, seven days per week. In multipractitioner installations, a separate appointment calendar is maintained for each clinician in the practice.

When the calendar is first called up, the present week (as determined by the system clock) is displayed. To display an earlier week, click the arrow at the left of the date field; to display a later week, click the arrow at the right of the date.

A



Appointments and events can be scheduled well into the future. The system is installed with one year's worth of blank calendar "pages," beginning with the week of installation; after six months, and every year thereafter, another year's worth of pages is added so that you can always schedule events at least six months, and usually l2-18 months, into the future.

Ten function buttons are provided at the top of the calendar window, as follows:

Help: brings up on-line Help description of the other buttons
Print day: produce hard copy of a single day's schedule from the weekly page being displayed.
Print week: produce hard copy of the entire week being displayed.
Save as template: use the current week's schedule as a template for future weeks
Fill from template: use the saved template to fill in standing appointments before entering new items.
Post: Take the scheduled appointments from the current calendar page, and record them, with appropriate charge data, in the individual patient account records.

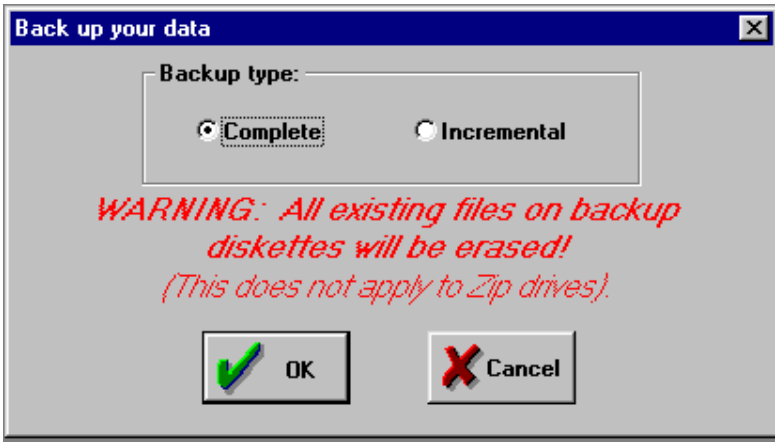
Format: select 15, 30 or 60 minute intervals for scheduling appointments; select 1, 2 or 3-line display mode; select your office opening and closing times.
Done: save all information on the present calendar page.
Clear: erase all information on the present calendar page.

B

Backing up your data

Purpose: *Create secure backup copies of your PM/2 data*
Menu selections: *Utilities, backup*
Accelerator key: *Ctrl + Alt + F12*

Sound computing practice dictates that you back up your data files regularly, and keep your backup copies in a separate physical location from your computer.



If you have a tape backup system, USE IT! Tape backups are faster and more comprehensive than diskette backups. But if you do not, ***PM/2 for Windows*** offers a fast, built-in diskette backup routine that can be activated from the menus. It creates .zip format backups (not to be confused with the ZIPdrive removable storage device) which are written to diskettes. The backup routine compresses the data (.dbf) and index (.ntx) files of PM/2 for Windows, not the program or system files. Therefore, disaster recovery may require your original installation diskettes as well as the backup diskettes.

Please note any warning or error messages which are received in the course of a backup; they could mean that your backup was incomplete or unsuccessful.

You may choose to perform either **complete** or **incremental** backups. Complete backups copy all data and index files, and are normally the preferred mode. Incremental backups copy only files which have been modified since the last backup was made. They are marginally faster and take less space, but may not contain 100% of the data needed for recovery in case of a hard disk failure (they must be used in conjunction with the previous Complete backup). Note that when using 3.5" diskettes, the backup routine erases any contents on the backup diskette prior to writing your backup, so make sure that you are not using a diskette containing important data for your backups.

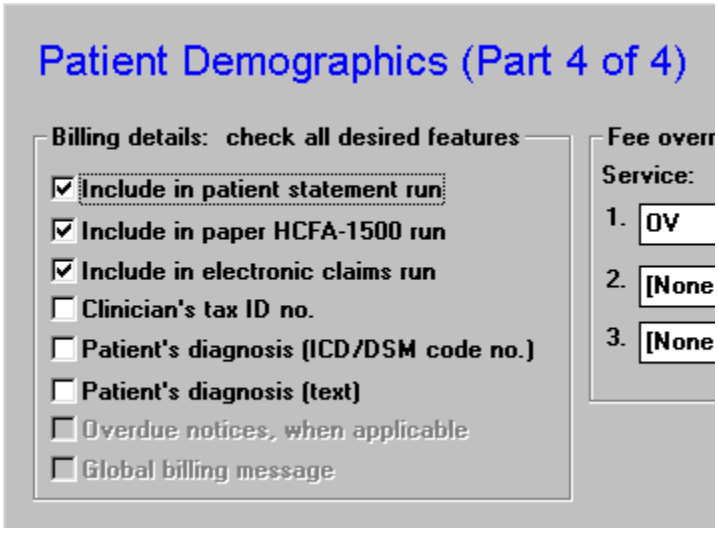
A good backup routine would utilize the Complete option once per month and the Incremental option on a weekly or daily basis, depending on the office's volume of work. **Always save and permanently file** at least one Complete backup per month, as well as all Incremental backups made since the preceding Complete backup. After a new Complete backup has been done, you may recycle the previous period's Incremental diskettes. But make sure to periodically "retire" a set of Complete backup diskettes, in case it should ever become necessary to reconstruct your data set as of a particular, earlier point in time.

Billing format options

General format options: Select either Simple or Detailed billing format from the Billing Menu. The Simple format is the more popular option, providing the patient with a straight chronological listing of charges, payments and amounts due. The Detailed format shows, in addition, the visit-by-visit breakdown of amounts received from patient, insurance and adjustments by visit. Please note that in order to successfully check off either Simple or Detailed format on the menu, all other PM/2 windows must be first be closed.

Billing messages: Select the text of global informational messages, and dunning notices, to be placed at the foot of each bill when applicable.

Individualized billing options: Part IV of Patient Demographics includes a number of items which may be included or excluded from the patient statements on an individualized basis. These items are normally included (checked) by default, but may be selective unchecked as shown:

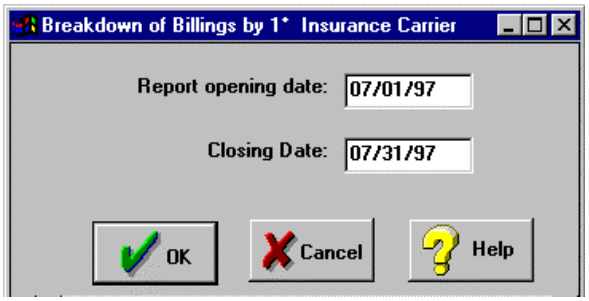


Billings, breakdown of, by insurance carrier

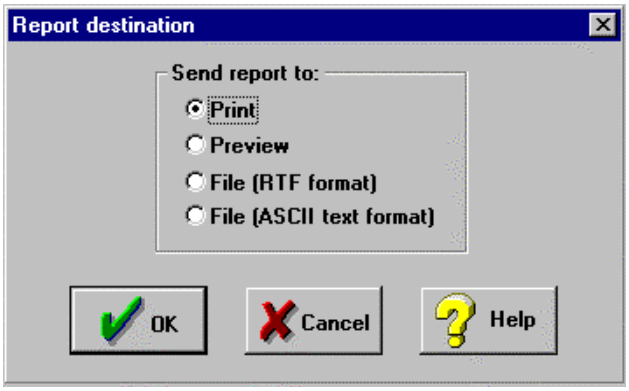
Purpose: *Show how your billings break down among the different insurance carriers*
Menu selections: *Reports, billings by..., primary insurance carrier*
Accelerator key: *Ctrl + F6*

B

This report presents your billings for any chosen period, broken down according to the listed Primary Insurance carrier. The default reporting period is the previous month, but this can be altered at the user's discretion. The report is activated with a standard Report Date Range Dialog box, as shown below:



and, as with all reports in PM/2 for Windows, can be directed to either printer, screen preview, or a file with a standard Report Destination dialog box, as shown below:



Related topics:

Report Date Range dialog box
Report Destination dialog box

Billings, breakdown of, by month of service

Purpose: *Present monthly totals of billings for any range of months*
Menu selections: *Reports, billings by..., month of service*
Accelerator key: *Ctrl + F7*
This report presents your billings for any chosen period, broken down according to the calendar month in which the service was rendered. The default reporting period is the previous calendar year, but this can be altered at the user's discretion. The report is activated with the standard Report Date Range dialog box, and output can be directed to printer, screen preview or disk file with the standard Report Destination dialog box.

Related topics:

Report Date Range dialog box
Report Destination dialog box

Billings, breakdown of, by place of service

Purpose: *Show amounts billed out for each service location listed in the Place of Service file*
Menu selections: *Reports, billings by..., place of service*
Accelerator key: *Ctrl + F4*

B

This report presents your billings for any chosen period, broken down according to the place where the service was rendered, i.e., office, hospital, secondary office, nursing home, school, etc. The default reporting period is the previous month, but this can be altered at the user's discretion. The report is activated with the standard Report Date Range dialog box, and output can be directed to printer, screen preview or disk file with the standard Report Destination dialog box.

Related topics:

Report Date Range dialog box
Report Destination dialog box

Billings, breakdown of, by Provider

Purpose: *Present totals of billings for each clinician in the practice*
Menu selections: *Reports, billings by..., primary Provider*
Accelerator key: *Ctrl + F3*

Presents your billings for any chosen period, broken down according to the clinician rendering each episode of service. The default reporting period is the previous calendar year, but this can be altered at the user's discretion. The report is activated with the standard Report Date Range dialog box, and output can be directed to

printer, screen preview or disk file with the standard Report Destination dialog box.

Related topics:

Report Date Range dialog box
Report Destination dialog box

Billings, breakdown of, by referral source

Purpose: *Show amounts billed out for each referral source listed in the Referral Sources file*
Menu selections: *Reports, billings by..., source of referral*
Accelerator key: *Ctrl + F5*

This report presents your billings for any chosen period, broken down according to the source of referral for the patient under treatment. The default reporting period is the previous month, but this can be altered at the user's discretion. The report is activated with the standard Report Date Range dialog box, and output can be directed to printer, screen preview or disk file with the standard Report Destination dialog box.

Related topics:

Report Date Range dialog box
Report Destination dialog box

Billings, breakdown of, by type of service

Purpose: *Show amounts billed out for each referral source listed in the Referral Sources file*
Menu selections: *Reports, billings by..., type of service*
Accelerator key: *Ctrl + F2*

B

This report presents your billings for any chosen period, broken down according to the type of service which was rendered. The default reporting period is the previous calendar month, but this can be altered at the user's discretion. The report is activated with the standard Report Date Range dialog box, and output can be directed to printer, screen preview or disk file with the standard Report Destination dialog box.

Related topics:

Report Date Range dialog box
Report Destination dialog box

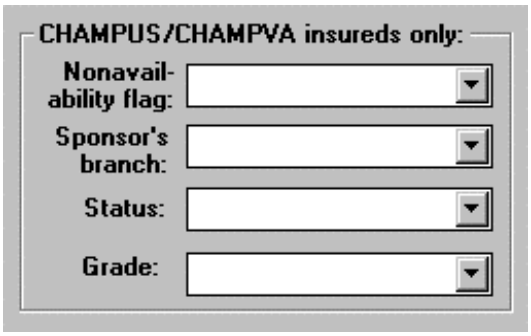
Browse window

Definition: a type of window displaying a database in tabular form. For example, the Referral Sources window or the Visit Codes Definition window.

Cancel Button

On data entry windows, the Cancel button causes all edits to be discarded and the data kept in its original form; if a new patient or other record was being defined, it is not saved. On dialog windows, the Cancel button causes the requested process to be terminated.

CHAMPUS data



C

CHAMPUS is a Federal health insurance program for family members of armed services members. CHAMPUS data is collected on screen 2 of the Insured Party window in ***PM/2 for Windows***, of which the illustration above is a detail.

There are 4 categories of data that are required for successful submission of a CHAMPUS or CHAMPVA claim. In CHAMPUS claims, the word "sponsor" has the same meaning as "insured" for civilian claims. The special details applicable to CHAMPUS claims are:

Sponsor's branch: This refers to the branch of the uniformed services to which the sponsor belongs (or belonged), e.g., Army, Navy, Air Force, Marine Corps, etc.

Non-availability flag: Depending on the facts of the case, you may have to certify either that the service rendered was not available within the military medical system, or that such the service was exempt from the need for such certification.

Status: refers to the sponsor's present status, e.g., active duty, retired, etc. There are numerous special categories within this field.

Grade: or rank of the sponsor. Each service has different labels for each grade, but there are established equivalencies across the services.

Clinical menu

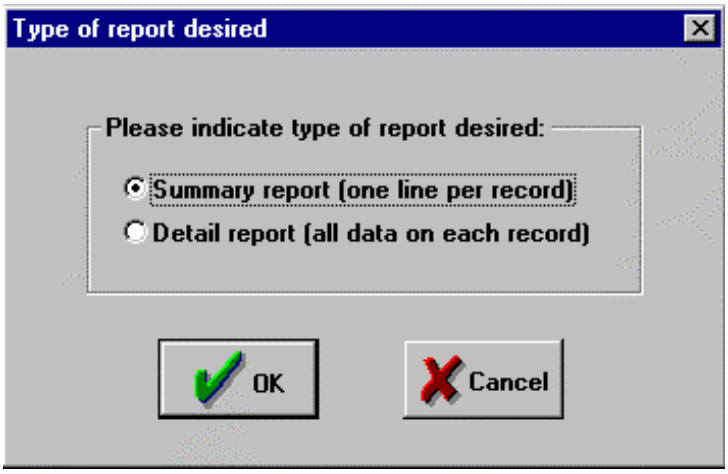
C

The Clinical menu opens onto a sub-menu giving access to the clinical features of PM/2 for Windows: progress notes, prescription and lab result tracking, maintaining the diagnosis code files (ICD and DSM), and the Treatment Plan Writer, which has not yet been translated from ***PM/2 for DOS.***

Clinician listings, summary vs. detail

When you click the Print button on the Provider Roster window, you bring up the Summary vs Detail dialog box, as shown in the illustration on the following page.

The Summary Report for this heading lists the data one line per record. Some fields are omitted for reasons of space.
The Detail report presents the data in paragraph form, with no fields omitted. If your database is large, we suggest using the Preview feature before printing, for the Detail reports can get quite lengthy.


Type of report desired
Please indicate type of report desired:
Summary report (one line per record)
Detail report (all data on each record)
OK
Cancel

Codes menu

This menu option leads to 6 submenus, one for each type of financial transaction recognized by PM/2 for patient accounts (visits, payments, credit adjustments, debit adjustments, miscellaneous charges and refunds). New codes may be entered via these screens and existing ones edited to meet your needs.

C

Related topics:

Codes, visit
Codes, payment
Codes, credit-adjustment
Codes, debit-adjustment
Codes, miscellaneous charge
Codes, refund

Codes, credit adjustment

Purpose: *Browse, edit, print or update the credit-adjustment codes listing*
Menu selections: *Files, Codes, credit adjustment*
Accelerator key: *Ctrl + F4*

This is PM/2's list of credit adjustment types. Use these codes for posting bookkeeping credits to the patient's account, as distinct from moneys received.

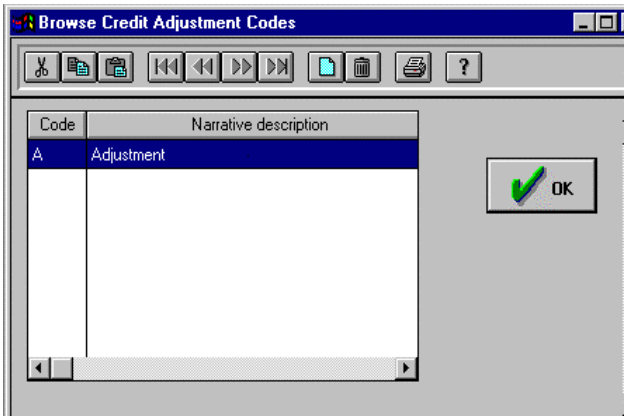
This distinction is very important for tax purposes, as cash-method taxpayers, as adjustments do not represent money received and thus must be tracked separately from cash income.

C

Each adjustment type has a 2-character **svctype** code which is assigned by the system for internal use, and a narrative **description** which is used on patient statements and reports. CPT4 codes and modifiers do not apply to adjustments because they are not professional services in nature.

PM/2 ships with a short list of adjustment types. You are not limited to these codes, but may add new codes to the list at any time by clicking the **Insert** toolbar button , or by selecting **Insert** on the Edit menu, to insert a new code. When you do so, a template will come up with the next available **svctype** code already entered; you need enter only the narrative description (e.g., "PruCare payment").

Unused codes may be deleted by pressing the **Delete** button or by using the **Delete** menu option on the Edit menu. However, you will not be permitted to delete codes under which visits have been recorded, for this would result in an "undefined code" error condition when such visits are encountered in the transaction data file.



You can use the **Arrow** toolbar buttons or their equivalents on the Edit menu, to quickly navigate through the file, which is presented in alphabetical order according to the **Description** field.

You can obtain a printout of the file by clicking the **Printer** button or by clicking **Print** on the Edit menu.

Related topics:

Codes, credit adjustment, adding new

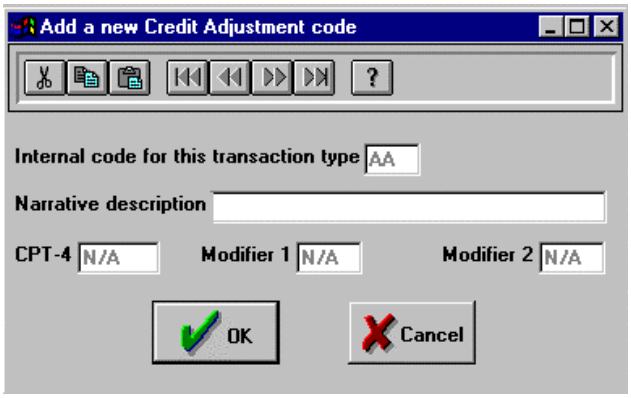
C

Codes, credit adjustment, adding new

This window is activated when you click the Insert button on the Credit Adjustment Codes browse window.

The **Narrative Description** field is the only one that needs to be completed on this window. Enter a brief (up to 30 character) narrative description of the service being defined, then click **OK** when you are satisfied with the description of your new transaction code, or **Cancel** to

abandon it.



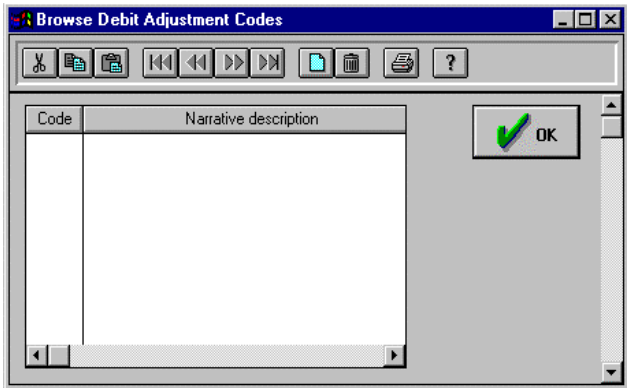
Before using this window, please review the existing set of credit adjustment codes to make certain that the code you need is not already part of the supplied set of transaction codes.

Related topics:

Codes, credit adjustment

Codes, debit adjustment

Purpose: *Browse, edit, print or update the debit-adjustment codes listing*
Menu selections: *Files, Codes, debit adjustment*
Accelerator key: *Ctrl + F5*



Debit adjustments are uncommon events and should be applied with caution. They are usually used to correct prior bookkeeping errors. In the example shown above, no debit adjustment codes at all have been defined; this is the way ***PM/2 for Windows*** ships. Most often, adjustments are credits, because you have decided to waive or write off certain moneys that would otherwise be due from the patient; a debit adjustment works in the opposite direction. Use a visit code or a miscellaneous charge code to post a charge for a specific service or event.

Each charge type has a 2-character svctype code which is assigned by the system for internal use, and a narrative description which is used on patient statements and reports. CPT4 codes and modifiers do not apply to debit adjustments because they are not professional services in nature.

"Debit adjustment" is the only element in the Debit Adjustment Code file as PM/2 is shipped. You are not limited to these codes, but may add new codes to the list at any time by clicking the Insert toolbar button , or by selecting Insert on the Edit menu, to insert a new code. When you do so, a template will come up with the next available svctype code already entered; you need enter only the narrative description.

Unused codes may be deleted by pressing the Delete button or by using the Delete menu option on the Edit menu.

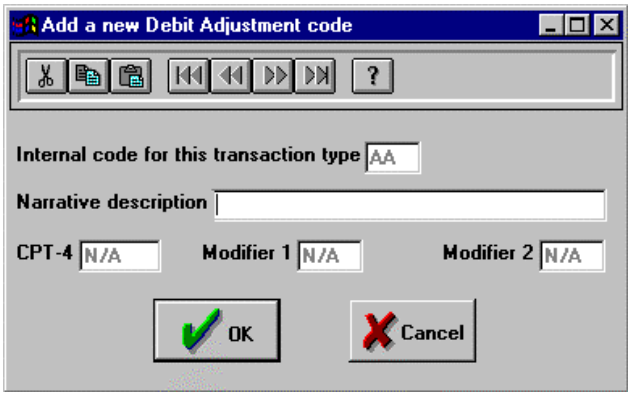
However, you will not be permitted to delete codes under which visits have been recorded, for this would result in an "undefined code" error condition when such visits are encountered in the transaction data file.

You can use the Arrow toolbar buttons or their equivalents on the Edit menu, to quickly navigate through the file, which is presented in alphabetical order according to the Description field.

You can obtain a printout of the file by clicking the Printer button or by clicking Print on the Edit menu.

C

Codes, debit adjustment, adding new



This window is activated when you click the Insert button on the Credit Adjustment Codes browse window.

The **Narrative Description** field is the only one that needs to be completed on this window. Enter a brief (up to 30 character) narrative description of the service being defined, then click **OK** when you are satisfied with the description of your new transaction code, or **Cancel** to abandon it.

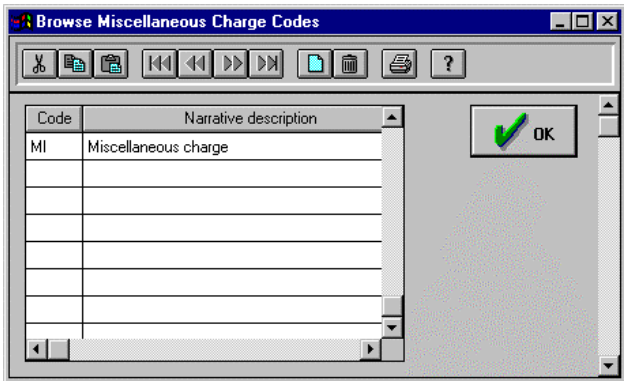
Before using this window, please review the existing set of debit adjustment codes to make certain that the code you need is not already part of the supplied set of transaction codes.

Related topics:

Codes, debit

Codes, miscellaneous charge

Purpose: *Browse, edit, print or update the miscellaneous-charge codes listing*
Menu selections: *Files, Codes, Miscellaneous charge*
Accelerator key: *Ctrl + F6*



This is PM/2's list of miscellaneous charge types. Use these codes for posting charges for services which are nonreimbursible by insurance because they are incidental rather than professional in nature, e.g., fees for broken appointments or returned checks. Each charge type has a 2-character **svctype** code which is assigned by the system for internal use, and a narrative **description** which is used on patient statements and reports. CPT4 codes and modifiers do not apply to miscellaneous charges because they are not professional services in nature.

PM/2 ships with a short list of miscellaneous charge types: sales taxes, returned check fees, and a general "Miscellaneous Charge" category. You are not limited to these codes, but may add new codes to the list at any time by clicking the **Insert** toolbar button , or by selecting **Insert** on the Edit menu, to insert a new code. When you do so, a template will come up with the next available **svctype** code already entered; you need enter only the narrative description.

Unused codes may be deleted by pressing the **Delete** button or by using the **Delete** menu option on the Edit menu. However, you will not be permitted to delete codes under which visits have been recorded, for this would result in an "undefined code" error condition when such visits are encountered in the transaction data file.

C

You can use the **Arrow** toolbar buttons or their equivalents on the Edit menu, to quickly navigate through the file, which is presented in alphabetical order according to the **Description** field.

You can obtain a printout of the file by clicking the **Printer** button or by clicking **Print** on the Edit menu.

Related topics:

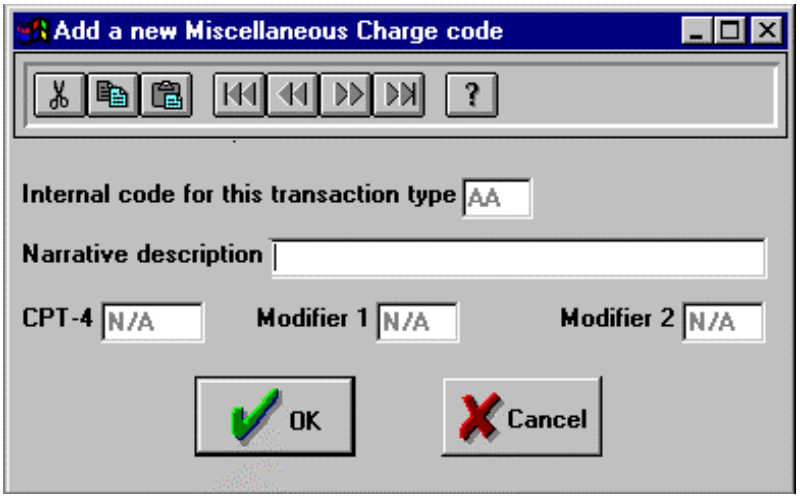
Codes, miscellaneous charge, adding new

Codes, miscellaneous charge, adding new

This window is activated when you click the Insert button on the Miscellaneous Charge Codes browse window.

The **Narrative Description** field is the only one that needs to be completed on this window. Enter a brief (up to 30 character) narrative description of the service being

defined, then click **OK** when you are satisfied with the description of your new transaction code, or **Cancel** to abandon it.



Before using this window, please review the existing set of miscellaneous charge codes to make certain that the code you need is not already part of the supplied set of transaction codes.

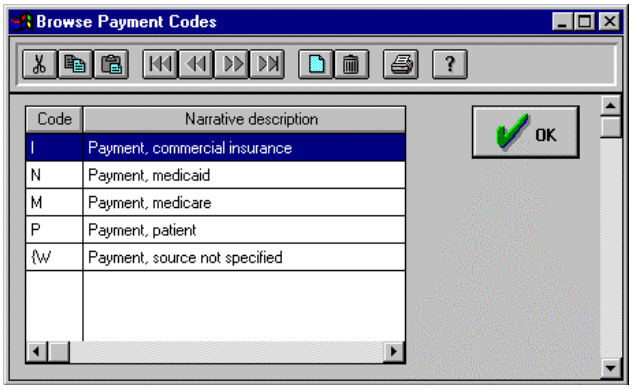
Related topics:

Codes, miscellaneous charge

C

Codes, payment

Purpose: *Browse, edit, print or update the payment codes listing*
Menu selections: *Files, Codes, Payment*
Accelerator key: *Ctrl + F3*



C

This is PM/2's list of defined payment types. Every payment accepted by your practice must be defined here. Each payment type has a 2-character **svctype** code which is assigned by the system for internal use, and a narrative **description** which is used on patient statements and reports. CPT4 codes and modifiers do not apply to payment types.

PM/2 ships with a short list of payment types: commercial insurance, medicare, medicaid, patient, and unspecified. You are not limited to these codes, but may add new codes to the list at any time by clicking the **Insert** toolbar button , or by selecting **Insert** on the Edit menu, to insert a new code. When you do so, a template will come up with the next available **svctype** code already entered; you need enter only the narrative description.

Unused codes may be deleted by pressing the **Delete** button or by using the **Delete** menu option on the Edit menu. However, you will not be permitted to delete codes under

which visits have been recorded, for this would result in an "undefined code" error condition when such visits are encountered in the transaction data file.

You can use the **Arrow** toolbar buttons or their equivalents on the Edit menu, to quickly navigate through the file, which is presented in alphabetical order according to the **Description** field.

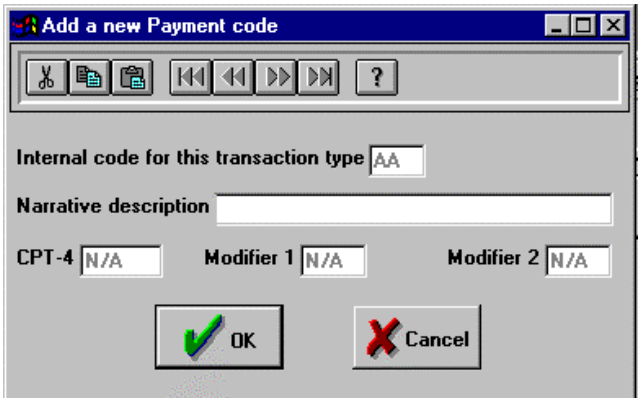
You can obtain a printout of the file by clicking the **Printer** button or by clicking **Print** on the Edit menu.

Related topics:

Codes, payment, adding new

C

Codes, payment, adding new



This window is activated when you click the Insert button on the Payment Codes browse window.
The **Narrative Description** field is the only one that needs to be completed on this window. Enter a brief (up to 30 character) narrative description of the service being defined, then click **OK** when you are satisfied with the

description of your new transaction code, or **Cancel** to abandon it.

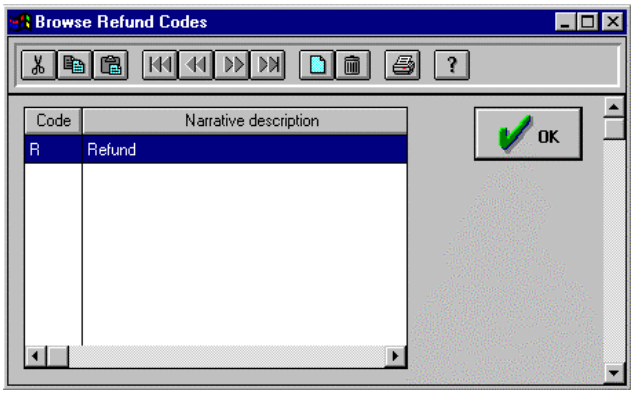
Before using this window, please review the existing set of payment codes to make certain that the code you need is not already part of the supplied set of transaction codes.

Related topic:

Codes, payment

Codes, refund

Purpose: *Browse, edit, print or update the refund codes listing*
Menu selections: *Files, Codes, Refund*
Accelerator key: *Ctrl + F7*



This is PM/2's list of defined refund types. Most practices will only need to employ the single predefined refund code "R", but you may add new codes to the list at any time by clicking the **Insert** toolbar button , or by selecting **Insert** on the Edit menu, to insert a new code. When you do so, a template will come up with the next available **svctype** code already entered; you need enter only the narrative description.

Unused codes may be deleted by pressing the **Delete** button or by using the **Delete** menu option on the Edit menu. However, you will not be permitted to delete codes under which visits have been recorded, for this would result in an "undefined code" error condition when such visits are encountered in the transaction data file.

You can use the **Arrow** toolbar buttons or their equivalents on the Edit menu, to quickly navigate through the file, which is presented in alphabetical order according to the **Description** field.

You can obtain a printout of the file by clicking the **Printer** button or by clicking **Print** on the Edit menu.

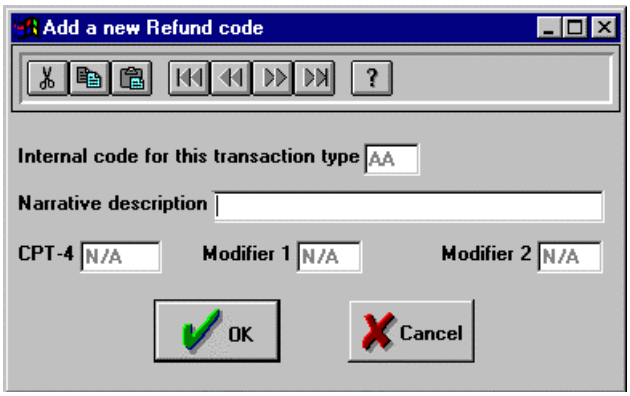
Related topics:

Codes, refund, adding new

Codes, refund, adding new

This window is activated when you click the Insert button on the Payment Codes browse window.

The **Narrative Description** field is the only one that needs to be completed on this window. Enter a brief (up to 30 character) narrative description of the service being defined, then click **OK** when you are satisfied with the description of your new transaction code, or **Cancel** to abandon it.



Before using this window, please review the existing set of refund codes to make certain that the code you need is not already part of the supplied set of transaction codes.

Related topics:

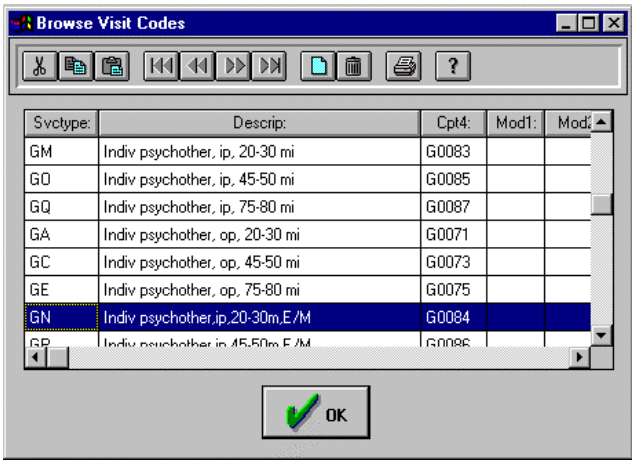
Payment codes

C

Codes, visit

Purpose: *Browse, edit, print or update the payment codes listing*
Menu selections: *Files, Codes, Payment*
Accelerator key: *Ctrl + F2*

This is PM/2's list of defined service types. Every professional service offered by your practice must be defined here. Each service has a 2-character **svctype** code which is assigned by the system for internal use, and a narrative **description** which is used on patient statements and reports. Most services will also have a 5-digit numerical CPT-4 code listing, which may have one or two modifiers appended to it for special purposes (e.g., services rendered by a social worker in a multispecialty group to a Medicare patient).



You are not limited to the default service code listing, but may

Related topics:

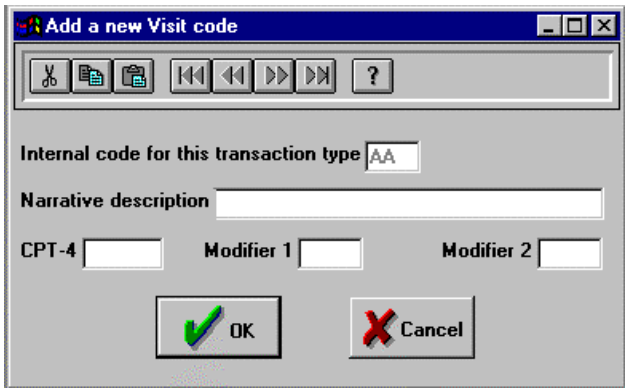
Codes, visit, adding new

C

Codes, visit, adding new

This window is activated when you click the Insert button on the Visit Codes browse window.

Use this window to define new visit codes for your copy of **PM/2 for Windows**. In this way you can keep up with national or regional additions to the procedural terminology manual, such as the Medicare "G" codes which became official in 1997, without having to send in for updates to your PM/2 system.



Please note that the transaction code, shown as "AC" on the illustration above, is only used internally by the system and is provided for informational purposes only. This is the code by which the system references your transactions internally, but you do not need to know or select these codes. Each time you add a transaction code, the next available digraph is chosen and displayed, but is not modifiable by the user.

Please enter CPT-4 and modifier codes for your new service definition, if applicable (see the discussion of these items on the Codes, visit window Help screen.

Related topics:

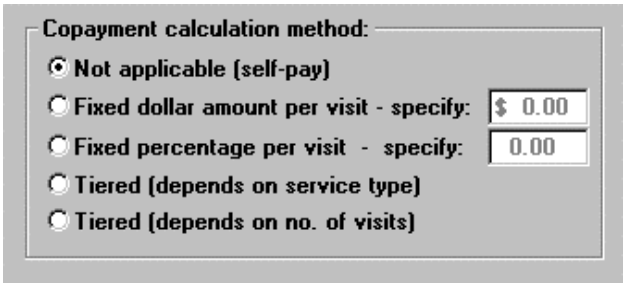
Codes, visit

Copayments

Purpose: *Record copayment information for determining patient vs. Insurance responsibility in billing*

Menu selections: *Details, copay/deductible*

Note: *The Details menu is only visible when the patient demographics window is being displayed on screen.*


Copayment calculation method:
Not applicable (self-pay)
Fixed dollar amount per visit - specify:
$ 0.00
Fixed percentage per visit - specify:
0.00
Tiered (depends on service type)
Tiered (depends on no. of visits)

Copayments are amounts due from insured patients for professional services. Deductibles and amounts in excess of annual or other limits are other types of patient responsibility for fees, but are handled separately. Copayments may be either **simple** or **tiered**.

Copayment information is one of the detail windows of the Patient Data Base.

In the case of **simple (fixed dollar)** copayments, there is a single field for the entry of the copayment dollar amount.

In the case of **tiered** copayments, which vary either by session count or by type of service provided, there is are fields for the entry of the copayment dollar amount due for each tier of service, whether determined by session count or type of service.

Related topic:

Copayments and deductibles
Copayment basis: fixed dollar amount

Copayment calculation method: fixed dollar amount

Select this option for patients covered by an insurance arrangement which leaves the patient responsible for the same dollar amount for each visit. Specify this dollar amount in the Copayment Amount field.

Related topics:

Copayment Amount

Copayment calculation method: fixed percentage of the fee

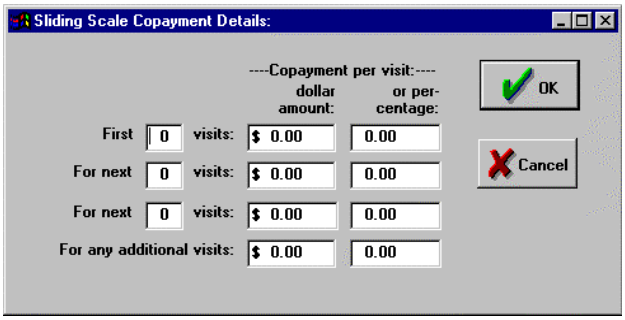
Select this option for patients covered by an insurance arrangement which leaves the patient responsible for the same percentage of your fee for each visit. Specify this percentage in the Copayment Percentage field.

C

Copayment calculation method: self-pay

Select this option under the following circumstances: (a) the patient has no insurance benefits available and therefore is responsible for the total cost of care; and (b) the patient is personally responsible for the cost of care and pays you directly; any available reimbursement goes directly to the patient, and you do not monitor transactions between the patient and the insurer.

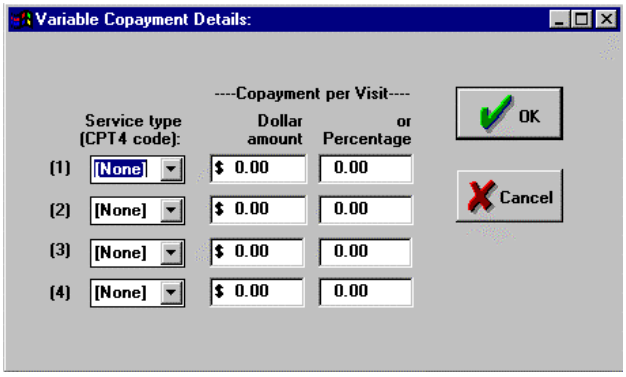
Copayment calculation method: tiered by no. of visits


Sliding Scale Copayment Details:
----Copayment per visit:----
dollar amount:
or percentage:
OK
Cancel
First 0 visits: $ 0.00 0.00
For next 0 visits: $ 0.00 0.00
For next 0 visits: $ 0.00 0.00
For any additional visits: $ 0.00 0.00

In this type of copayment arrangement, the patient is responsible for differing dollar amounts (or percentages of your fee) depending on the number of visits that the patient has had. Typically, these copayment amounts increase over the course of treatment in a not-at-all-subtle effort to discourage extended treatments, or at least to reduce the insurance carrier's financial burden for ongoing treatments.

Copayment calculation method: tiered by service type

In this type of copayment arrangement, the patient is responsible for differing dollar amounts (or percentages of your fee) depending on the nature of the service rendered. Typically, these copayment amounts are smallest for initial or emergency consultations, intermediate for occasional services like medication checks, and highest for ongoing services such as individual psychotherapy.



Copayment percentage

In the case of **fixed percentage** copayments, where the patient is responsible for a fixed proportion of your fee without regard either to visit count or type of service, there is a single field for the entry of the copayment percentage.

In the case of **tiered** copayments, which vary either by session count or by type of service provided, there is are fields for the entry of the copayment percentage due for each tier of service, whether determined by session count or type of service.

Copayments and Deductibles window

Purpose: *Specify copayments and deductibles applicable to a specified patient*
Menu selections: *Details, Copay/deductible*
Accelerator key: *Ctrl + N*

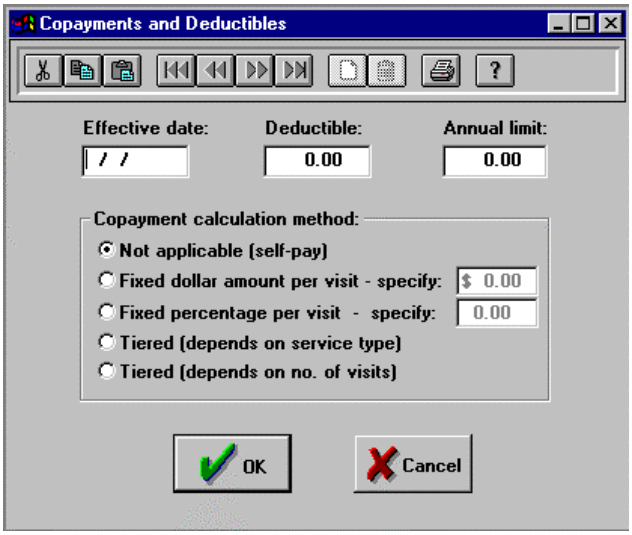
The upper portion of this window is used for entering the annual **deductible** of the patient's primary insurance coverage; the **plan year** starting date, which may be different from January 1; and the **annual dollar cap** which is the upper limit beyond which payments by the primary insurance carrier cease. Another way of looking at the

dollar cap is that it is the point at which the patient's copayment goes to 100%; but it is special because it is determined by the totaling the insurance company payout to date, rather than a set number of visits.

The lower portion of the window specifies the type of copayment. The options are:

- self-pay
- fixed dollar amount
- fixed percentage
- tiered by no. of visits
- tiered by service type

Each of these methods is described individually in the preceding sections.



If you select either of the tiered copayment methods, a second special window is opened to collect the data relevant to the selected copayment method.

Related topics:

Copayments, tiered
Copayments, variable

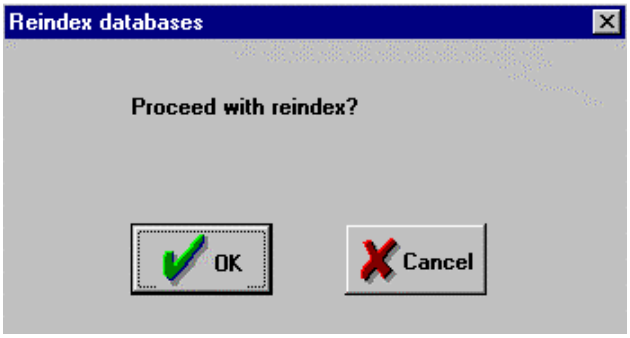
CPT4 codes

A standard coding system for describing medical services, the *Current Procedural Terminology, 4th ed.*, published by the American Medical Association. The psychiatric section of CPT4 is included with PM/2 for Windows; you may add additional codes as needed (see **Codes, visit**).

C

Databases, reindexing of

Purpose: *Update the database index files*
Menu selections: **Utilities, Reindex**
Accelerator key: *Ctrl + Alt + F11*



Database programs, such as ***PM/2 for Windows***, rely on **indexes** for fast retrieval of the information they contain. Index files are dynamic data structures which can require periodic maintenance. The Reindex option allows you to perform such maintenance, either on a scheduled preventive basis or "as needed" if the system ever fails to retrieve information you know to be stored in it.

Reindexing requires exclusive access to the databases. Therefore you should

a) shut down all other windows of PM/2;
b) log out any other network users of PM/2; and
c) close any other applications which are accessing PM/2's database or index files, prior to running this option.

In normal operation, the name of each file being reindexed will show on the window as the operation is taking place. Please take note of any messages received during the reindex operation. These may indicate failure of the reindex on one or more files and should not be ignored. Repeat steps (a) through (c) above; if the problem persists, contact Technical Support.

Date of service

The date on which a service was actually rendered.

Related topics:

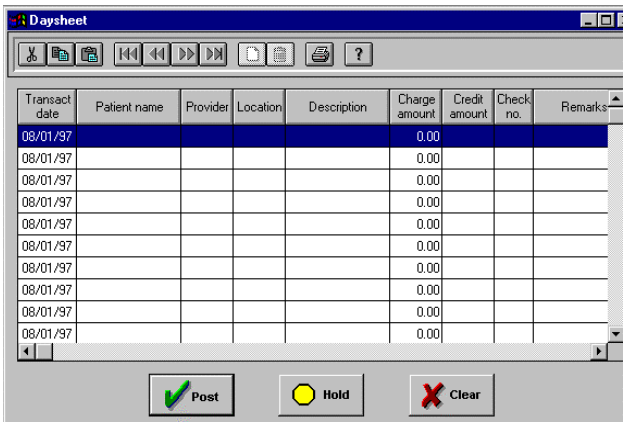
Posting date

Daysheet

Purpose: *Post visits and/or payments to patient accounts*
Menu selections: *Files, Financials, Daysheet*
Accelerator key: *F10*

The Daysheet is a window for the entry of visits or payments ("transactions") by one or more patients, which do not necessarily have to occur all on the same date. Simply type in the date of the transaction and first few letters of the name of the patient; the name will be verified against patient names on file in the database, and default provider IDs, service locations, service descriptions and charge amounts will be entered if available. Narrative remarks of any length can be entered in the Remarks field.

The Daysheet file is a temporary holding file or "buffer". Visits and payments are not posted from the daysheet to the individual patient records until you click the **Post** button at the bottom of the Daysheet window.



If you have entered as much data onto the Daysheet as you wish, but are not yet ready to post it to the patient ledgers, you can either click the **Minimize** button at the upper left hand corner of the window, or click the **Hold** button at the bottom of the Daysheet window. The only difference between these methods is that the Minimize button keeps the window active in iconized form (visible on the Windows 95 toolbar) while the Hold button closes the window; both buttons keep the Daysheet data intact.

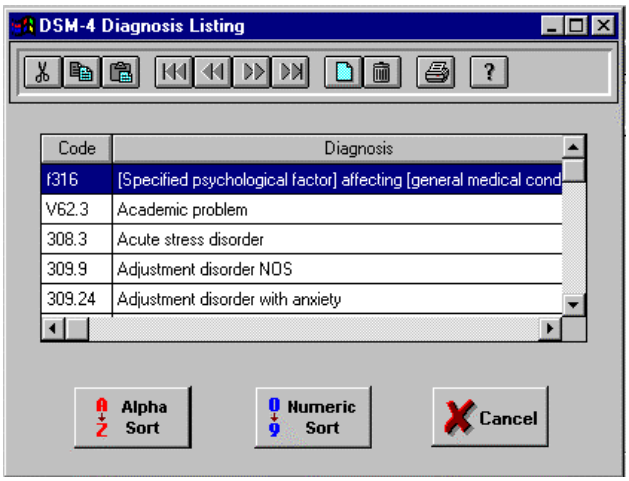
If you wish to abandon the Daysheet and erase rather than post all of the transactions on it, click the **Clear** button at the bottom of the window.

Diagnosis file window, DSM-4

Purpose: *Display the DSM-4 diagnosis listing*
Menu selections: *Files, Clinical, Diagnoses, DSM-4*
Accelerator key: *Ctrl + F12*

A scrollable listing of the defined diagnoses and their code numbers is displayed in the main browse window. Three push buttons are provided at the bottom of the window:

The **Alphabetic Sort** button causes the listing to be displayed in alphabetical order. This is the default.



The **Numeric Sort** button causes the listing to be displayed in numerical order.

The **Cancel** button closes the window.

The standard Edit menu and toolbars are functional on this window.

Note that the listing produced by the **Print** buttons sorted in the same order (alphabetical or numerical) as you have selected for the browse window itself, as shown in the example on the following page.

D

PM/2 for Windows

Demonstration System

DSM-4 Diagnosis List (alphal

osis

mic problem

Diagnosis file window, ICD9

Purpose: *Display the DSM-4 diagnosis listing*
Menu selections: *Files, Clinical, Diagnoses, DSM-4*
Accelerator key: *Ctrl + F11*

A scrollable listing of the defined diagnoses and their code numbers is displayed in the main browse window. Three push buttons are provided at the bottom of the window:

The **Alphabetic Sort** button causes the listing to be displayed in alphabetical order. This is the default.

The **Numeric Sort** button causes the listing to be displayed in numerical order.

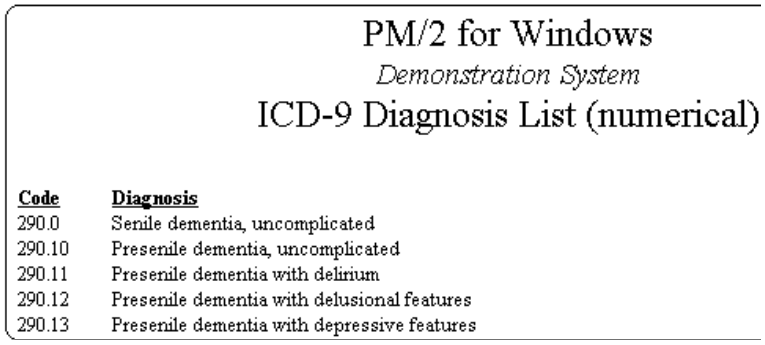
The **Cancel** button closes the window.

The standard Edit menu and toolbars are functional on this window.

Note that the listing produced by the **Print** button is sorted in the same order (alphabetical or numerical) as you have

D

selected for the browse window itself, as shown in the example below.



PM/2 for Windows

Demonstration System

ICD-9 Diagnosis List (numerical)

Code	Diagnosis
290.0	Senile dementia, uncomplicated
290.10	Presenile dementia, uncomplicated
290.11	Presenile dementia with delirium
290.12	Presenile dementia with delusional features
290.13	Presenile dementia with depressive features

Diagnosis files, adding new entries

Use this window to add additional diagnoses (such as general medical diagnoses) to the default list of psychiatric diagnoses from ICD9 or DSM4. Click OK save the new diagnosis, incorporating it into the file; or Cancel to abandon it.

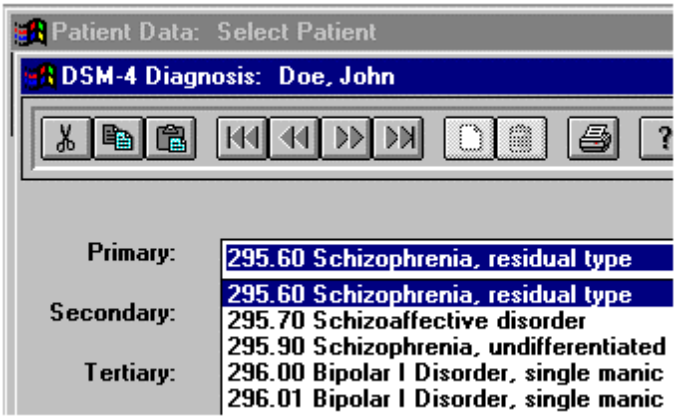
D

Diagnosis window (DSM-4)

Purpose: *Display the DSM-4 diagnosis for a given patient*
Menu selections: *Details, DSM-4 diagnosis*
Accelerator key: *Ctrl-F*

This window is used for entering the clinical diagnoses on a specific patient. To browse or modify the master diagnosis files, see the **Diagnosis file window, DSM4** or the **Diagnosis file window, ICD9.**

Up to three diagnoses, in DSM4 coding, can be entered on this window (primary, secondary, or tertiary). You can either type in the diagnosis or click the arrow icon at the right-hand end of the diagnosis field, which causes a numerically sorted listing of the diagnosis codes to pop up.



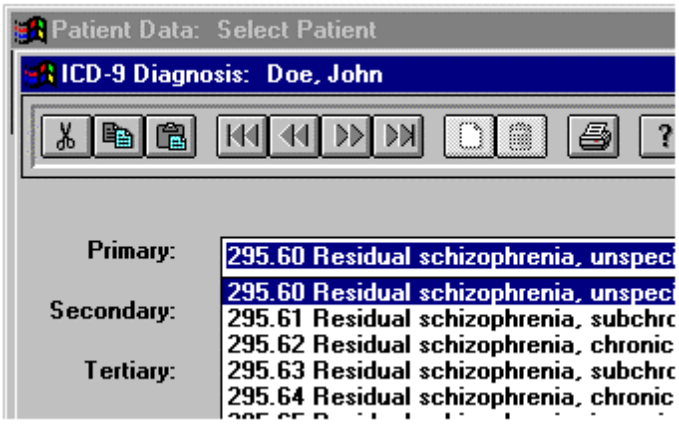
Only diagnoses presently on file can be selected via this window. To add a new diagnosis to the DSM4 diagnosis file, make the following menu selections: **File, Clinical, Diagnosis, DSM4**. Once entered, new diagnoses are merged into the diagnosis file and can be used just like diagnoses supplied with the original file.

The diagnoses entered on this window stay with the patient

until modified. Thus, they will come up by default on each visit that is posted; but, like all defaults in PM/2, can be overridden as needed for specific, individual visits. For example, you may be treating a patient with a chronic diagnosis but a particular service may be related to a transitory, acute problem; in such a case it is more accurate (and may enhance reimbursement opportunities) to cite the acute diagnosis.

Diagnosis window (ICD-9)

Purpose: *Display the ICD-9 diagnosis for a given patient*
Menu selections: *Details, ICD-9 diagnosis*
Accelerator key: *Ctrl-G*
This window is used for entering the clinical diagnoses on a specific patient. To browse or modify the master diagnosis files, see the **Diagnosis file window, DSM4** or the **Diagnosis file window, ICD9**.



Up to three diagnoses, in ICD9 coding, can be entered on this window (primary, secondary, or tertiary). You can type in the diagnosis or click the arrow icon at the right-hand end of the diagnosis field, which causes a numerically sorted listing of the diagnosis codes to pop up.

Only diagnoses presently on file can be selected via this window. To add a new diagnosis to the ICD9 diagnosis file, make the following menu selections: **File, Clinical, Diagnosis, ICD9**. Once entered, new diagnoses are merged into the diagnosis file and can be used just like diagnoses supplied with the original file.

The diagnoses entered on this window stay with the patient until modified. Thus, they will come up by default on each visit that is posted; but, like all defaults in PM/2, can be

overridden as needed for specific, individual visits. For example, you may be treating a patient with a chronic diagnosis but a particular service may be related to a transitory, acute problem; in such a case it is more accurate (and may enhance reimbursement opportunities) to cite the acute diagnosis.

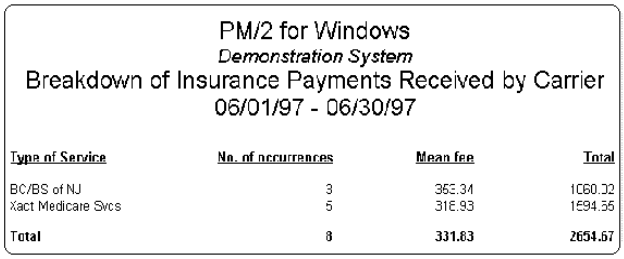
Dunning messages

See description under **Billing Format Options (page 49, above)**

Earnings, Breakdown of, by insurance carrier

Purpose: *Analyze practice earnings according to type of insurance.*
Menu selections: *Reports, earnings by..., insurance carrier*
Accelerator key: *Ctrl-F8*

Sample output of this report:



PM/2 for Windows
Demonstration System
Breakdown of Insurance Payments Received by Carrier
06/01/97 - 06/30/97

Type of Service	No. of occurrences	Mean fee	Total
BC/BS of NJ	3	353.34	1060.02
Xact Medicare Svcs	5	318.93	1594.65
Total	**8**	**331.83**	**2654.67**

Note that this report presents actual moneys earned, not amounts billed out.

Related topic:

Billings, breakdown of, by insurance carrier

Earnings, breakdown of, by place of service

Purpose: *Analyze practice earnings according to place of service*
Menu selections: *Reports, earnings by..., place of service*
Accelerator key: *Ctrl-F10*
This report is useful for comparing the relative productivity of various sites in practices with more than one location. Its format closely follows that of the Earnings by Insurance Carrier report detailed in the previous section.

Related topic:

Billings, breakdown of, by insurance carrier

Earnings, breakdown of, patient vs. Insurance payment

Purpose: *Analyze practice earnings according to the source of payment*
Menu selections: *Reports, earnings by..., patient vs. Insurance payment*
Accelerator key: *Ctrl-F9*

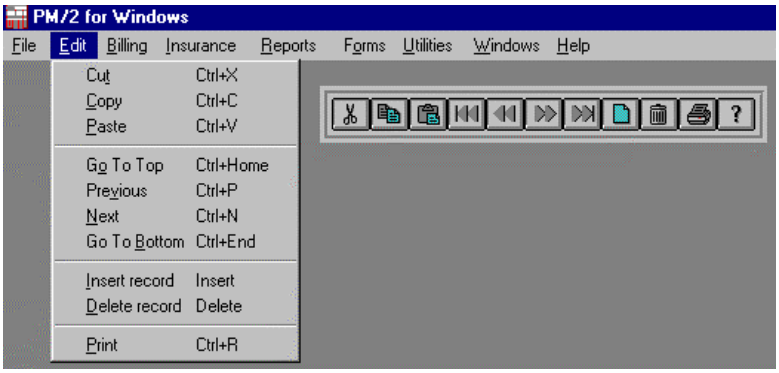
This report is useful for comparing the relative contribution of self-pay and insured patients in the practice. This can be an important datum in evaluating proposed managed care contracts. The format of this report closely follows that of the Earnings by Insurance Carrier report described above.

Edit menu

This menu is open on all windows which have editing functions, i.e. those where data entry is possible. The menu contains three groups of functions, which are described below.

Note that most windows also display a toolbar, illustrated at the right of the above figure. Each icon on the toolbar corresponds to an option on the edit menu; the identical function is activated by clicking the icon or the menu item.

When an icon, or a menu selection, is unavailable on a given window, it is "dimmed out" so that it remains visible as a placeholder, but the dimmed item cannot be activated.



Group 1: Cut, Copy, Paste: These functions enable use of the Windows Clipboard within ***PM/2 for Windows*** or between ***PM/2 for Windows*** and other Windows applications. See the descriptions of the individual options under **Toolbar buttons: cut/copy/paste.**

Group 2: Top, Previous, Next, Bottom: These functions control movement of the record point up and down through databases on windows that contain browse displays. See the descriptions of the individual options under **Toolbar buttons: top / previous / next / bottom.**

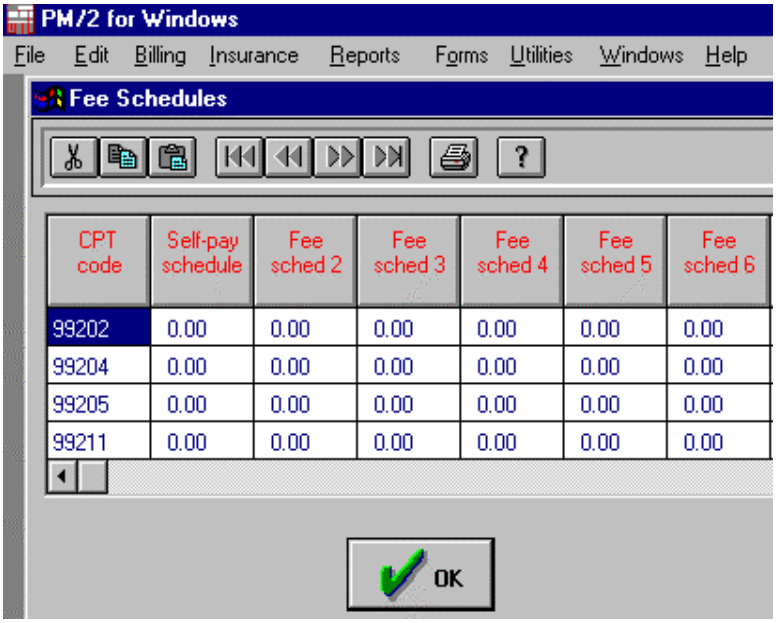
Group 3: Print: This function is available only on windows that have associated print functions. When available, it produces a printout of the database or record associated with the window; this varies with the specific window on view.

E

E

Fee schedules

Purpose: *Set up standard prices for services, based on type of service and insurance coverage*
Menu selections: *Files, Fee schedules*
Accelerator key: *F4*


PM/2 for Windows
File Edit Billing Insurance Reports Forms Utilities Windows Help
Fee Schedules
CPT code
Self-pay schedule
Fee sched 2
Fee sched 3
Fee sched 4
Fee sched 5
Fee sched 6
99202 0.00 0.00 0.00 0.00 0.00 0.00
99204 0.00 0.00 0.00 0.00 0.00 0.00
99205 0.00 0.00 0.00 0.00 0.00 0.00
99211 0.00 0.00 0.00 0.00 0.00 0.00
OK

Please do not be intimidated by the many rows and columns of this window. It is simply a table which gives you the opportunity to enter a "self-pay" fee for each defined service (your "standard" fee schedule, which applies when the patient does not have insurance coverage). The window also enables you to enter up to nine additional Medicare, Medicaid, managed-care or other fee schedules, which will automatically come into play when the system determines that the patient has such coverage.

There will always be many blank spaces in this table, for no one clinician ever needs to establish a fee for every single CPT4 service, and it is rare to have as many as the ten different fee schedules for which the window has room.

If you are setting up Medicare or managed-care fee schedules, you must explicitly tell the system which column goes with which carrier. This is done on the **Insurance carrier file, browsing** window, where there is a space for "Fee Schedule" in insurance carrier's row. See the illustration below, where the Fee Schedule column has been moved next to the carrier's name for clarity.

File menu

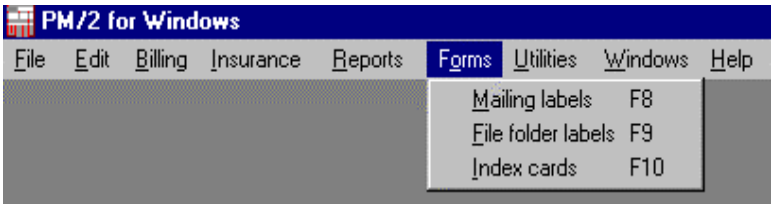
This menu provides access to all of the databases of PM/2.

Financials menu

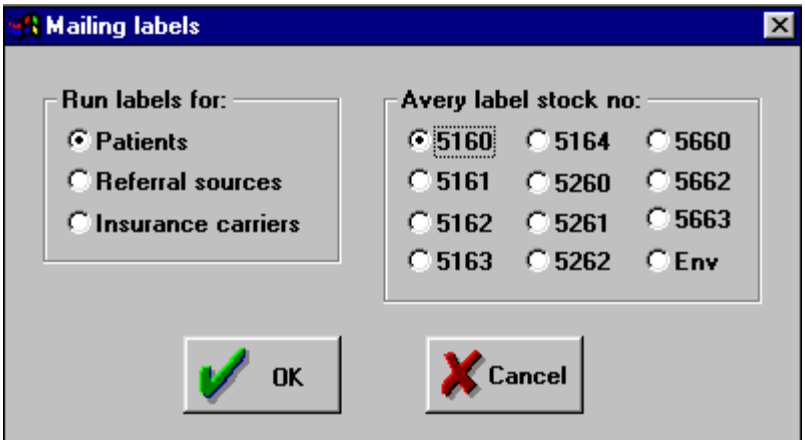
This menu option leads to a submenu with two options: **Patient Account Record** for displaying and posting financial data to individual patient accounts, and **Daysheet** for an efficient posting form for multiple accounts.

Forms generator menu

F


PM/2 for Windows
File Edit Billing Insurance Reports Forms Utilities Windows Help
Mailing labels F8
File folder labels F9
Index cards F10

A variety of clinically useful forms and labels can be produced on your printer using the options of this menu. When producing labels, a dialog box will come up to ask you what type of label stock you are using, in terms of Avery code numbers (Avery is the leading producer of PC labels, and competing companies will generally identify their products as "equivalent to Avery *nnnn*" for compatibility purposes. Mailing labels can be produced not only for patients, but also for referral sources and insurance carriers: Please note that by using the "ENV" option you may print directly onto envelopes rather than onto labels if your printer is physically capable of handling envelopes.



F

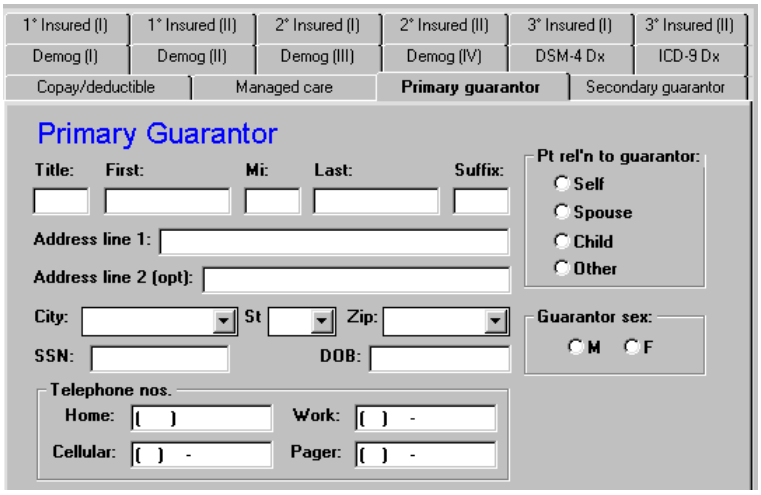
Getting started: registering patients

See Tutorial 5 for a detailed description of the process of registering a new patient.

Guarantor window

Purpose: *Identify the person or entity responsible for the patient's bills*

The guarantor is the person or other legal entity that is financially responsible for the costs of the patient's care. A guarantor is **not** an insurance company, except in the specific circumstance of a consultation (such as an Independent Medical Evaluation) ordered by the insurance company itself; rather, a guarantor is the patient himself, or the parent, spouse, guardian, attorney, conservator, or trustee of the patient.

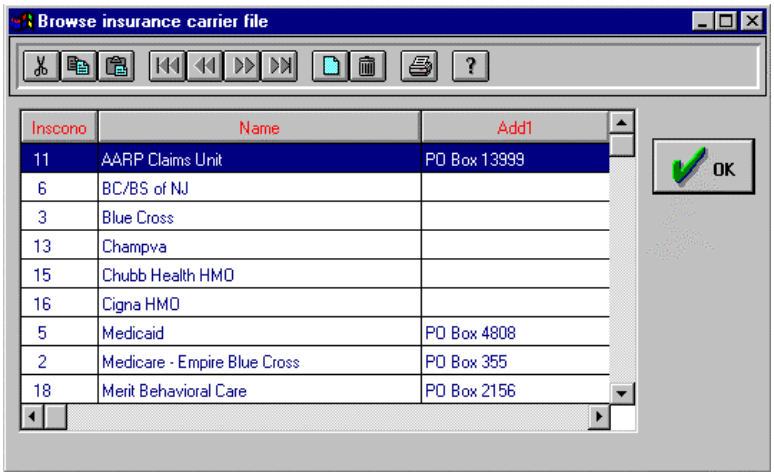


Please take particular care, in the "patient relation to guarantor" field, to remember that you are defining the relationship **of** the patient **to** the guarantor, so that "child", for example, means that the patient is the child of the guarantor, not vice-versa.

Both a primary and a secondary guarantor may be defined. By default, the primary guarantor is the patient himself and there is no secondary guarantor.

Insurance carrier file

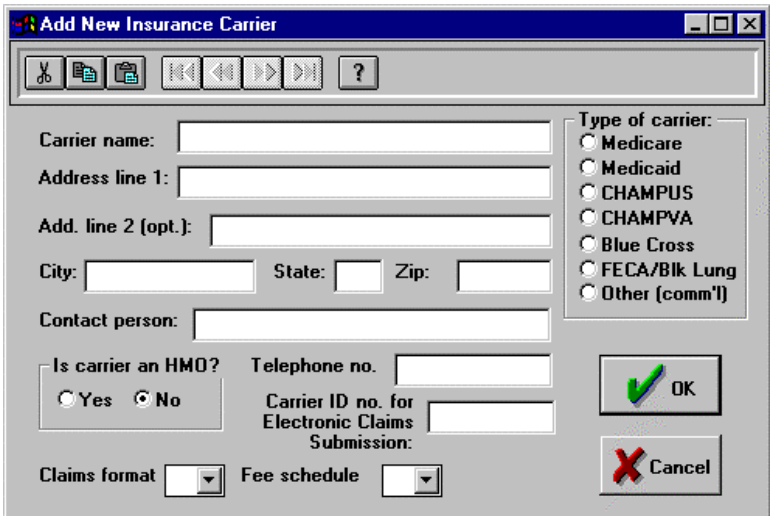
Purpose: *Browse or edit the file of insurance carriers*
Menu selections: *Files, insurance carriers*
Accelerator key: *F9*



A scrollable listing of all of the insurance carriers that you have entered into the system.

To enter a new carrier, click the **Insert** toolbar button or select **Insert** on the Edit menu. To delete a carrier record, click the **Delete** button or select **Delete** on the Edit menu. Use caution in deleting records from this database, however, as doing so will leave undefined the Insurance Carrier ID on any patient records that have been set up with that ID.

Insurance carrier file, adding new entries



A template for adding new companies to the Insurance Carriers file.

Carrier name, address, city, state, zip, contact person and **telephone no**. are self-explanatory.

If you intent to submit claims electronically, please the field for **ID no. for electronic claims submission**. This code (which unfortunately is not universal but rather is assigned by each claims clearing house) serves to uniquely identify the insurance carrier to the clearing house. As such, it must be provided for every carrier to which you intend to submit electronic claims.

It is important to check one of the seven options in the **Type of Carrier** box in the upper right hand corner of the window. You must tell the system explicitly whether each carrier is a Blue Cross plan, a Medicare intermediary, a commercial insurance company, etc.; the system cannot infer the type of carrier from the carrier's name. This information is used for two purposes:

- When submitting claims on paper, your selection here

controls which of the seven checkboxes in field 1 of the HCFA-1500 form is checked. If omitted, no box is checked, but your claim *may* be processed.

- When submitting claims electronically, it is even more important, for it controls the placement of your provider identification number in the claims file. If omitted or entered incorrectly, your provider ID no. will be omitted or incorrectly placed in the electronic claims file, and your claim *will be rejected.*

The **Claims Format** field is not used at this time in ***PM/2 for Windows.***

Click **OK** to confirm the addition to the file or **Cancel** to abandon it.

Related topics:

Insurance carrier file
Insurance carrier file, printing

Insurance carrier file, printing

Two different types of printed listings **(Summary** and **Detail**) can be selected for printing via this dialog window.

The **Summary Report**, which is the default, is a columnar report listing code number, name, address and telephone number for each carrier in your Insurance carrier file.

The **Detail Report** is a paragraph-style report which shows all of the above data plus drug registration, license, UPIN, Blue Cross and Medicaid numbers, and up to ten fields of user-defined data, for each carrier in your Insurance carrier file.

PM/2 for Windows

Demonstration System

Insurance Carrier Listing (summary report)

No	Name	Address	City, State, Zip
11	AARP Claims Unit	PO Box 13999	Phila. PA 19187-0216
6	BC/BS of NJ		
3	Blue Cross		
13	Champva		
15	Chubb Health HMO		
16	Cigna HMO		
5	Medicaid	PO Box 4808	Trenton NJ 08650-4808
2	Medicare - Empire Blue Cross	PO Box 355	Crompond NY 10517

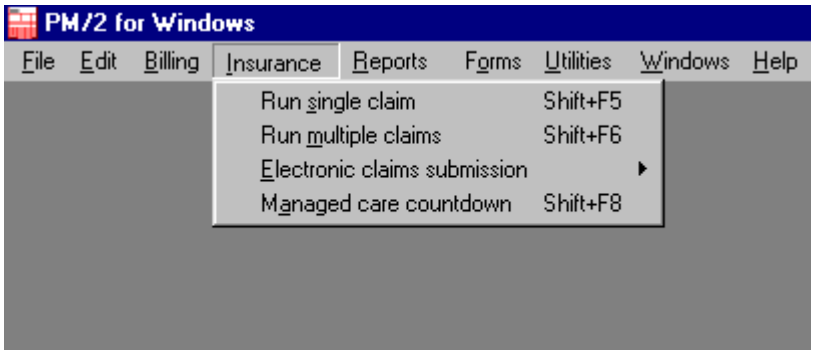
Select the report you desire by clicking the appropriate option, then click the OK button. Or click Cancel to cancel production of the report and return to the Insurance carrier file browse window.

Related topics:

Insurance carrier file

Insurance claim forms, running of

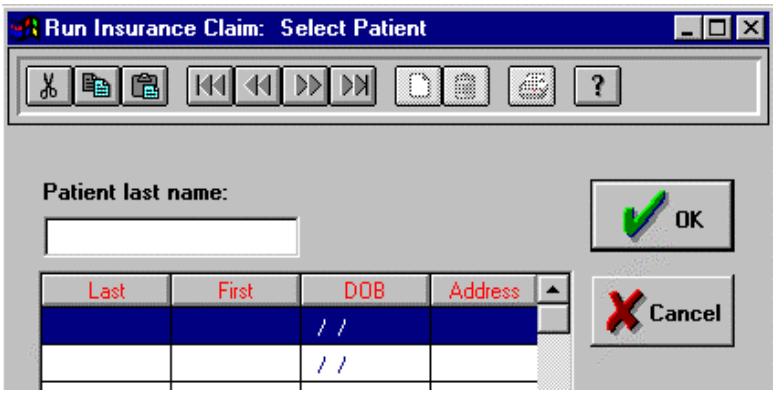
Purpose: *Print HCFA-1500 insurance claim forms*
Menu selections: *Insurance, Run claims (single/multiple)*
Accelerator key: *Shift + F5 (single), Shift + F6 (multiple)*


PM/2 for Windows
File Edit Billing Insurance Reports Forms Utilities Windows Help
Run single claim Shift+F5
Run multiple claims Shift+F6
Electronic claims submission
Managed care countdown Shift+F8

You may run insurance claim forms either singly (by patient) or in groups, using the first or second options on this menu .

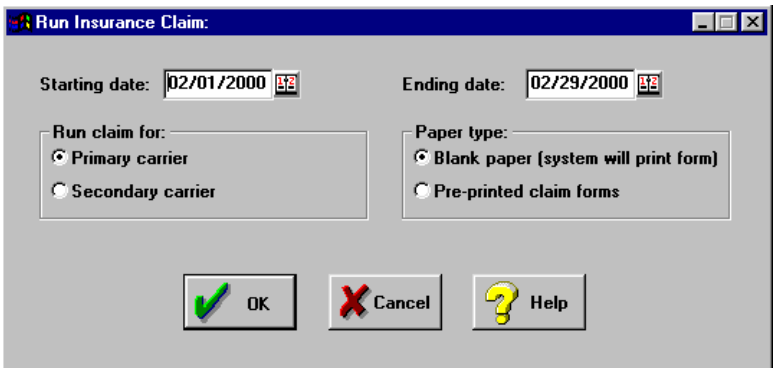
When running claims singly, a standard Patient Selection Window comes up (see next page). Select the patient for whom you wish to generate a claim form, and then click OK. This will bring up a second window on which you specify the first and last dates of the period to be covered by the claim form. Click OK again to run your form, as illustrated below:

Patient selection window:



Claim period selection window (note the Help button at the bottom, which is present on some dialog windows which do not have toolbar buttons):

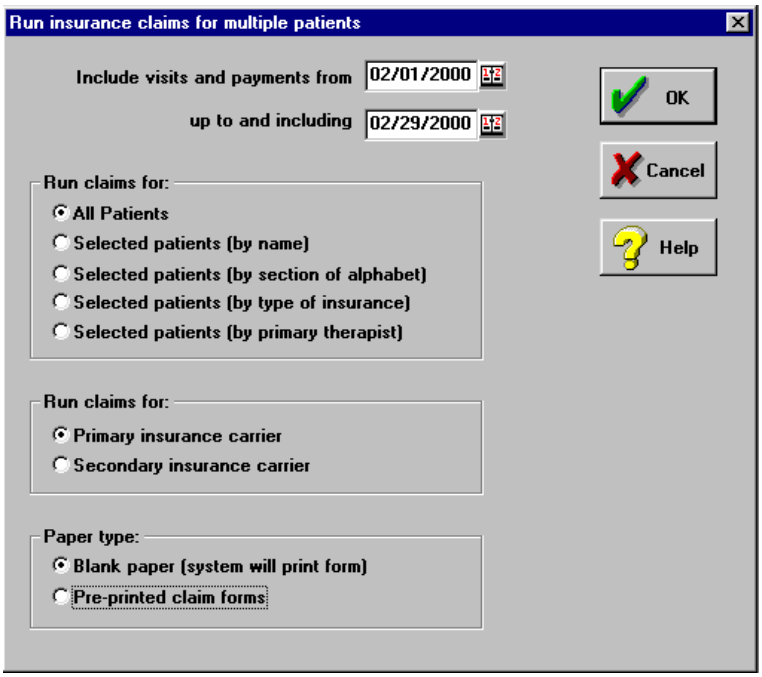
Running claims as a group is only a little different. Select Multiple Claims from the menu (see previous page) and then select either "all patients" (see below) or a specified subgroup of patients from the Multiple Insurance Claims window (illustrated on the following page).



The claim information may be either printed along with the form itself onto plain blank paper, or it may be printed out onto standard HCFA-1500 claim forms, which must be loaded into your printer. Both cut-sheet and tractor-feed versions of this form are available from a large number of commercial medical printers. Medicare policy varies by carrier as to whether the red (preprinted) forms are required; see Appendix E.

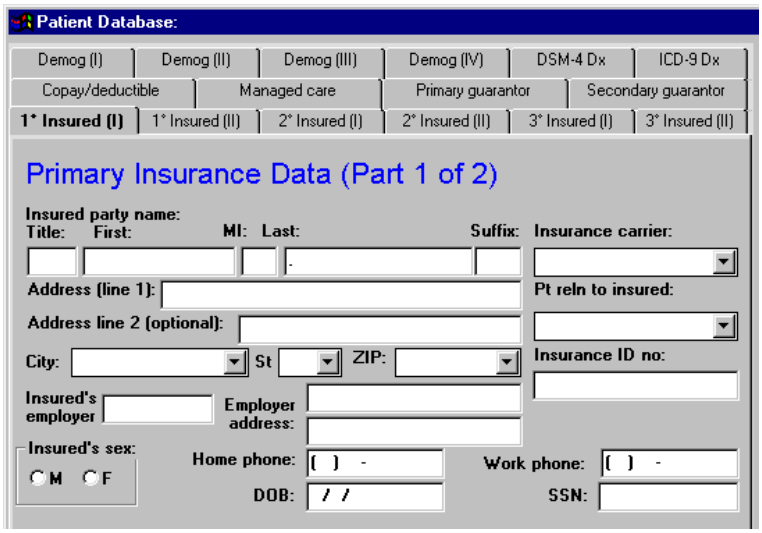
Note the little calendar icon to the right of the date fields. If you double-click this icon, a miniature monthly calendar pops up, from which you may select a date rather than typing it in.

On the multiple claim selection window, note that the selection by provider is grayed out only in solo-practitioner installation; this criterion is available when PM/2 for Windows is installed in multi-practitioner mode.



Insured party data, part 1

Purpose: *Collect basic information on the insured person for each patient.*



This window contains demographic data on the person

holding the **primary** health insurance coverage on the patient whose name appears in the caption bar at the top of the window. An identical window is available for recording secondary and tertiary insured data.

Be certain to enter all of the name, address, telephone number, employer, and related information for the **insured person,** not the patient.

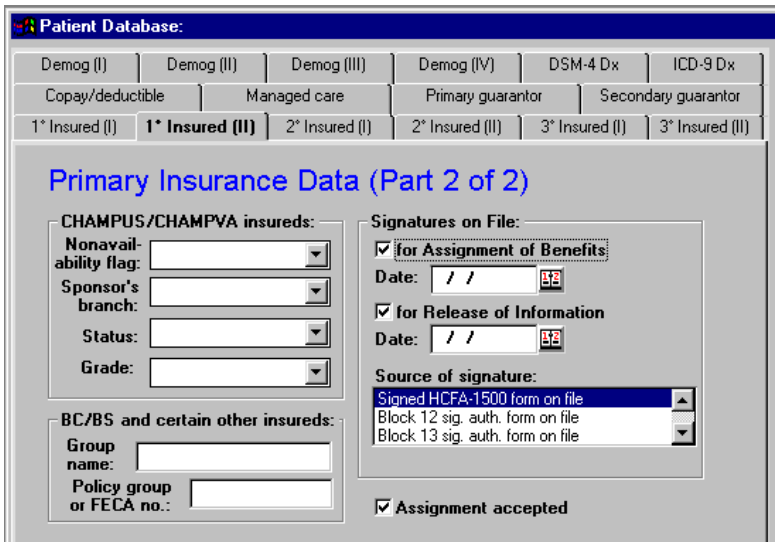
Please note that you will not be permitted to save the data on this window until you complete the 3 most critical data items on it: the insured party last name, the insurance carrier, and the insurance ID number.

Insured party data, part 2

Purpose: *Collect supplementary information on the insured person for each patient.*

Part 2 of the Primary Insurance window contains 4 categories of data:

CHAMPUS/CHAMPVA data: required for persons covered by these plans; disregard for other persons.



Group name and number: complete only if applicable (usually to Blue Cross insureds).

Signature on File and Signature Source: these must be completed for all claims you intend to file electronically. The Signature on File fields (but not necessarily the Signature Source field) must also be completed if you wish to have the computer print out "Signature on File" in boxes 12 and 13 of the HCFA-1500 insurance claim form. This is the default; it is the easiest way to provide the required documentation of the signature on file.

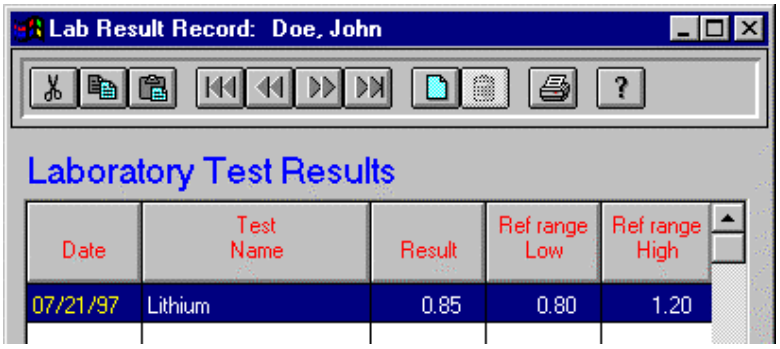
Assignment accepted: this box must be checked if you wish to have insurance benefits paid to you directly rather than to the patient.

An identical window is available for recording secondary and tertiary insured data.

I

Laboratory results, browsing

Purpose: *Review the lab result file and/or enter new results*
Menu selections: *File, Clinical, Lab results*
Accelerator key: *Ctrl + F10*

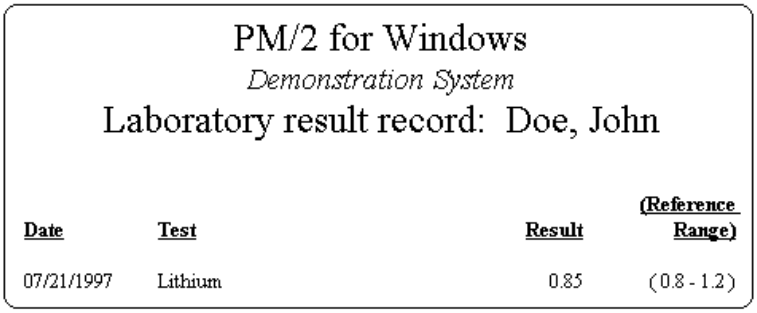


This window provides a chronological record, in flow-sheet style, of all laboratory results obtained on a given patient.

Use the **Insert** button to insert new laboratory result records.

Use the **Arrow** buttons to move up and down in the lab result browser, or use the scroll bar at the right hand side of the browser.

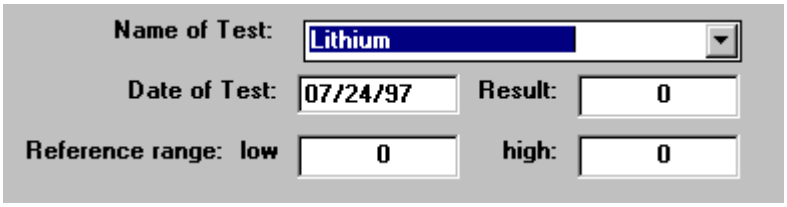
Use the **Print** button to print out the flow sheet. The appearance of the laboratory results printout is illustrated on the following page:


PM/2 for Windows
Demonstration System
Laboratory result record: Doe, John

Date	Test	Result	(Reference Range)
07/21/1997	Lithium	0.85	(0.8 - 1.2)

L

Laboratory results, entering



This simple data entry window pops up when you click the **Insert** toolbar button on the Lab Results Browse window (see previous entry), or when you select Insert on the Edit menu of that window.

There are five data fields on this window:

- **Name of Test**
- **Date of Test**
- **Result**
- **Reference Range (high)**
- **Reference Range (low)**

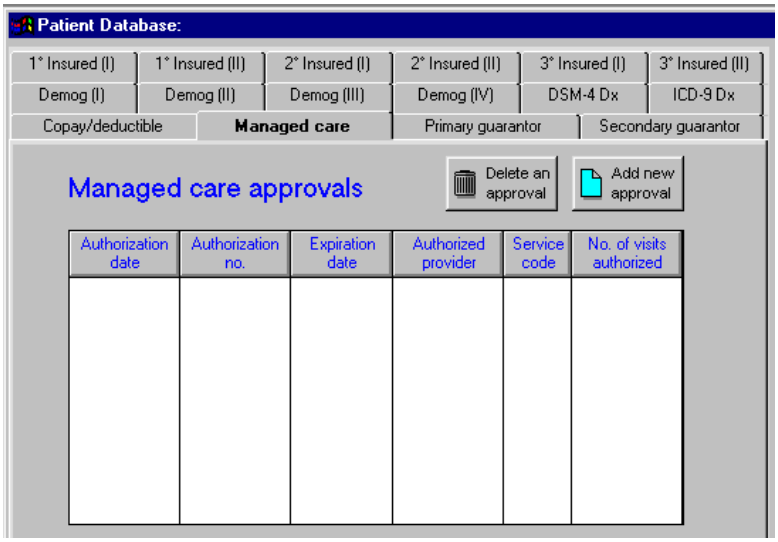
The first three fields are required in all cases, while the latter two are optional. The reference range may be entered with each value received, because different clinical laboratories will report different reference ranges, or even different units of measurement, for the same test.

A database is provided which contains the names of a number of lab tests that are commonly ordered in psychiatry. If convenient, you can click the arrow icon at the right of the **Name of Test** field and click on the name

of the test, rather than typing it in.

Managed care authorizations

Purpose: *Track managed-care treatment authorizations for a given patient*

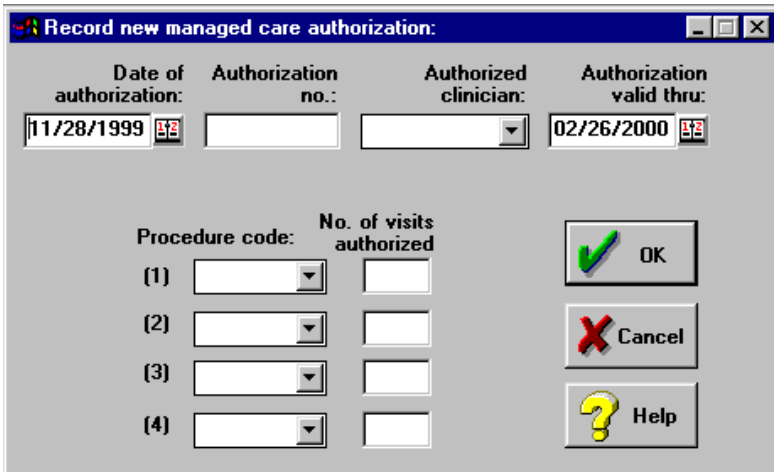


On this tab of the Patient Database window, you record each managed care authorization received on behalf of the patient, including (as applicable) authorization dates, numbers, expiration dates, the clinician authorized to render services, the specific service authorized (by CPT4 code) and the number of episodes of such service (visits) that have been authorized.

To add or delete records to the managed care file for the present patient, click the indicated buttons at the top of the window. When you are finished making your changes, click the **OK** button to exit from this window.

Managed care authorizations, entering new

Click the **Add New Approval** button on the Managed Care Window (see previous section) to bring up a template for a new managed care authorization for this patient.



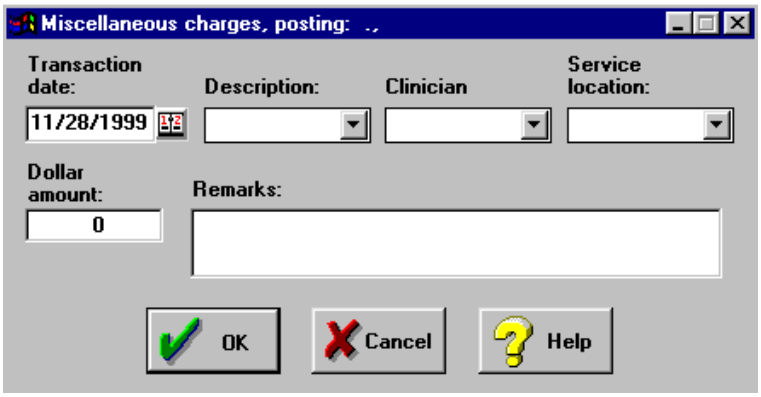
Multiple concurrent authorizations are allowed, to cover the case where the managed care organization authorizes (for example) an initial consultation at one rate with one clinician, followed by ongoing treatment sessions at a lower rate with another clinician.

Miscellaneous charges, posting of

Each of the data fields on this window should be completed when posting a miscellaneous charge to the patient's account.

The **transaction date** field refers to the date of the actual charge, not the posting date.

The **description** field has a downward-pointing arrow at the right. Click this icon if you wish to see the various types of Miscellaneous Charges that have been defined in your system.



Please note that the **Clinician** and **Service Location** fields will be dimmed out (inaccessible) when there are fewer than two entries in the Clinician and Service Location databases, respectively, because the user does not have a choice to make when the database is empty or contains only one entry.

As usual, click **OK** to confirm your selections and post the data, or **Cancel** to abandon the data on this window.

OK Button

On Data Windows such as Patient Demographics, the OK Button causes all edits on the window to be saved, then closes the window and returns the user to the previously active window, if any, or to the menu system, if no other windows were open. On Dialog Windows such as Run Statement, the OK button tells PM/2 for Windows to go ahead and produce the desired report, document, etc.

P

Password system

Purpose: *Prevent unauthorized access to your data*
Menu selections: *Utilities, Password*
Accelerator key: *Shift + Alt + F3*

PM/2 for Windows features a password security system designed to limit access to PM/2 for Windows to authorized users.

Access levels

Five access levels are defined in PM/2 for Windows. From lowest to highest, these are:

1. **Clerical:** access to posting and billing/insurance claim production only.
2. **Clinical:** 1 + access to progress notes, prescriptions and lab result records.
3. **Financial (individual):** 2 + access to user's own financial reports
4. **Financial (group):** 3 + access to aggregated financial reports (applies to multipractitioner installations only).
5. **Administrator:** 4 + access to password- and access-level assignment window.

Adding new authorized users

New users can be added to the system by completing all of the fields on this window, then pressing the **OK** button.

In multipractitioner installations, this window includes a field labeled "Clinician ID". If the user is given an access level below 5, his or her access rights will be limited to data pertaining to this clinician; reports will be "censored" so that patient or financial data of the other clinicians in the practice will not be accessible.

PM/2 for Windows allows you to assign passwords and access rights to an unlimited number of users.

Each user is identified by 3 or 4 data fields:

- User Name
- Password
- Access Level
- Clinician ID (in multi-practitioner installations only)

Only users with Access Level 5 have access to the Password Browser.

Users may be added or deleted by clicking the **Insert** or **Delete** toolbar buttons, respectively.

Clinician ID

A User ID may be associated with a Clinician ID in multipractitioner installations of ***PM/2 for Windows***. This allows the system to be used in large offices where Dr. A's assistant (for example) has rights to work on Dr. A's data but not Dr. B's. If the Clinician ID is omitted, the user has rights to access all data in the system, subject to his or her access level.

Password, specifications of

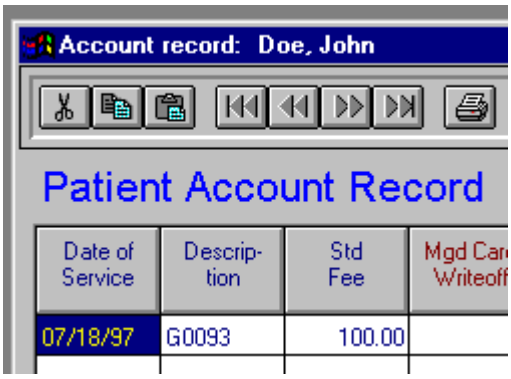
The password is a 3 to 8 character string which must be entered within 3 tries when initially logging in to ***PM/2 for Windows.*** It is stored in an encrypted form which should be secure against most amateur efforts at decryption. Users are cautioned, however, that (a) all encryption systems are vulnerable to sufficiently concerted attack and (b) in most real-world circumstances, physical security of the computer (with its data files) is more important than password security of the application program.

Password system, user name

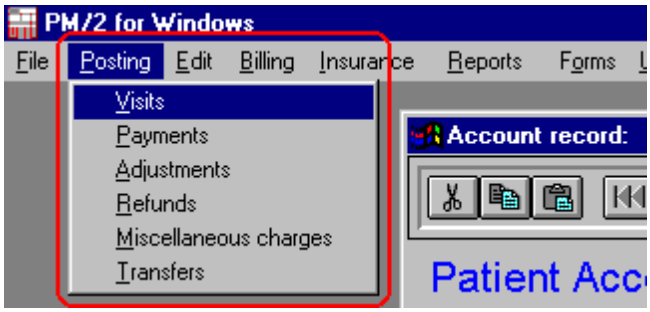
User name is the user's actual name or nickname (as opposed to password). When logging in, the user will be prompted for both user name and password. Both of these must match the versions on file in order for the log-in to be permitted.

Patient account record

Purpose: *Display and update the patient financial account*
Menu selections: *File, financials, patient account record*
Accelerator key: *F11*



The Patient Account Record window is the main source of information about the patient's financial history. It provides a ledger-style display of each visit or other charge in the patient's record, with columns for payment and adjustment information and balances. It is designed with special reference to managed care issues, such as contractual **vs.** standard fees, risk-pool withholds, copayments and deductibles, etc.



A special Posting Menu is provided when this when is displayed. Activate the Posting Menu when you need to record new charges, payments, adjustments and corrections.

Here is a column-by-column description of the Patient Account Record display:

- **Date:** the date on which the visit or other chargeable event occurred. This is not necessarily the date of posting, which is automatically recorded. Since there are more columns in the display than can be shown at any one time, the display scrolls horizontally. However, the Date of Service column is "frozen" and does not scroll.

- **Description:** the CPT4 code of the chargeable event, if available; otherwise the narrative description.

- **Clinician**: this column does not appear in solo practitioner installations. In multipractitioner installations, the name of the clinician rendering the service.

- **Standard fee:** the usual, non-discounted fee charged for the service (see next item).

- **Managed-care writeoff:** the difference between the standard fee (see previous item) and the contractual fee (see next item) in managed-care or medicare situations, i.e. the scheduled fee set by the managed-care plan or by Medicare. It may be zero if you elect to make your

standard fee the same as the contract fee .

- **Place of service**: this column does not appear in practices where only one place of service (e.g. office) has been defined. Otherwise, the place where each episode of service occurred.

- **Contract fee:** if applicable, the scheduled fee applicable to this service as set by the patient's managed-care company or by Medicare. The same as the Standard Fee for non-Medicare, non-managed care patients.

- **Copayment:** the payment owed by the patient for this particular episode of service, exclusive of any deductibles or caps, which are handled separately. Copay is equal to the Standard Fee in the case of self-pay patients and patients with traditional indemnity insurance who pay you in full and are reimbursed directly by the insurance company.

- **Deductible:** the portion of the charge, otherwise payable by insurance, which is not paid by insurance because the patient's deductible has not been met.

- **Overlimit amount:** the portion of the charge, otherwise payable by insurance, which is not paid by insurance because the patient's annual dollar limit (cap) has been reached.

- **Adjustments:** amounts which you choose to add or subtract from the amount due for this visit. Do not use this column for managed-care writeoffs or risk-pool withholds, which are handled separately. Adjustments increase or decrease patient responsibility estimates; they do not affect insurance responsibility.

- **Patient responsibility:** the amount due from the patient for this visit, as computed by the system. It is the total of Copay Outstanding plus unsatisfied Deductibles plus all amounts in excess of the plan

Dollar Limit for the year, and forms PM/2's best estimate of how much the patient is personally responsible for, per visit, in managed care and Medicare situations. In self-pay situations, it is simply equal to the fee amount less any payments already made on account of this visit.

- **Patient payments:** The amount actually received from the patient on account of this particular visit. May be greater than, equal to, or less than the Copay amount due as specified in the previous column.

- **Patient balance:** The difference between the two preceding columns.

- **Riskpool withhold:** Amounts payable by insurance, but withheld as part of a managed-care risk pool system.

- **Primary insurance responsibility:** PM/2's best estimate of the amount of insurance benefits available for this episode of service. Calculated by subtracting Estimated Patient Responsibility from Contract Fee.

- **Primary insurance payments:** The total amount actually received (cash in hand) from the primary insurance carrier, on account of this visit. Actual money received, not an estimate!

- **Insurance balance:** Amounts still due from the primary insurance carrier (=estimated primary insurance responsibility - primary insurance payments).

- **Secondary insurance payments:** The total amount actually received (cash in hand) from the secondary insurance carrier, on account of this visit. Actual money received, not an estimate!

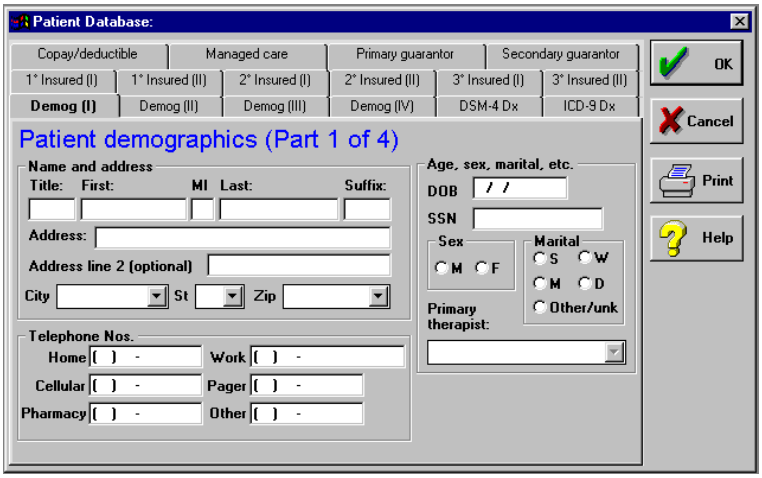
- **Total balance:** Total balance outstanding on this visit, from all sources. Equals (Contract fee - Patient Payments - Primary Insurance Payments - Secondary

Insurance Payments - all Adjustments) .

- **Remarks:** Any text comments you wish to save that pertain to the present visit. Length is not limited to the size of the field on the display.

Patient demographics: overview

All patient demographic data is recorded in a series of tabbed windows, as shown below:



Each of the sub-windows can be reached by clicking the appropriate tab on the main demographics window.

Patient demographics: part 1

Purpose: *Record and display basic patient identifying data*
Menu selections: *File, Patient*
Accelerator key: *F3*

This is the master Patient Demographics window. This is where you enter the patient's name and address, telephone numbers, age, sex, social security number, etc. In multipractitioner installations, you also enter the patient's primary therapist on this window.

This window is part of a series. To move on to the next window in the series, click the tab for the desired window. See the illustration under the previous heading.

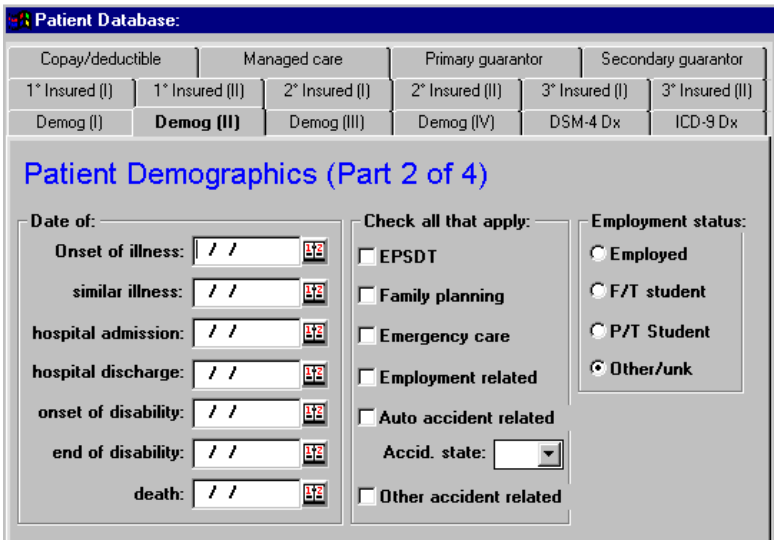
Patient demographics: part 2

Purpose: *Record and display additional patient identifying data*

This window contains **dates** and **check boxes** pertinent to the HCFA-1500 insurance claim form.

Dates:

- **Onset of illness**: must be a specific date, even if the illness is chronic. Descriptive terms such as "unknown" or "insidious" may not be used.



- **Similar illness**: keeping in mind the pre-existing condition exclusion common to many health insurance plans, you are asked the approximate date of any episode of an illness suffered by the patient that is "the same or similar" to the present illness.

- **Hospital admission and discharge**: leave blank if the patient was not admitted as a hospital inpatient during the present episode of illness.

- **Onset/end of disability**: leave blank if no disability claim is to be filed for the patient.

- **Treatment plan update**: not yet implemented.

- **Death**: applies only to claims filed after the death of the patient; leave blank otherwise.

Check boxes:

- **EPSDT**: must be checked for Medicaid patients enrolled in **E**arly **P**revention, **S**creening, **D**etection, **T**reatment programs (uncommon in psychiatry).

- **Family planning**: must be checked for such services

when provided to a Medicaid recipient.

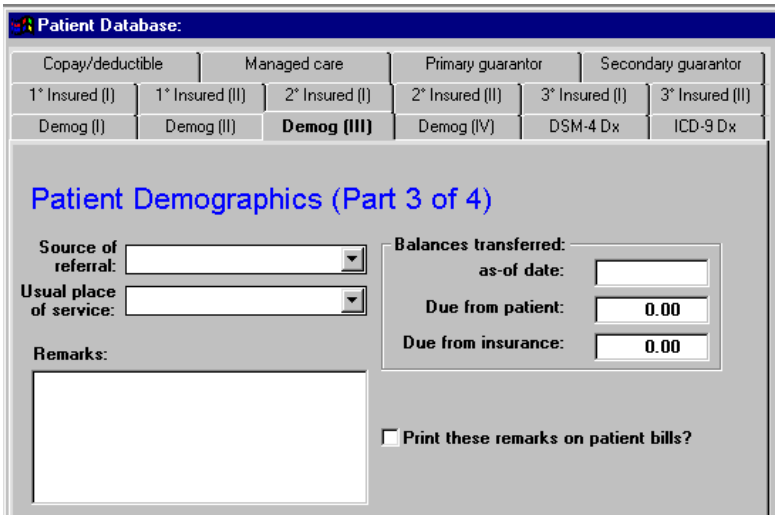
- **Emergency care**: checking this box may improve your chances of being reimbursed for services which otherwise require prior approval from the carrier.

- **Auto accident related**: this box must be checked (and the associated **state** field completed) for claims which will be submitted under PIP or similar automobile insurance reimbursement systems.

- **Other accident related**: check this box when services may have a liability aspect other than automobile accident-related.

Patient demographics: part 3

Purpose: *Record and display additional patient identifying data*



Source of referral: Click the arrow icon at the right of the field to bring up a scrollable list of referral sources already known to the system. Or type in the name of the referral source; if it does not match any entry on the list, you will be prompted for permission to add the name to the referral

source data base.

Usual place of service: Click the arrow icon at the right of the field to bring up a scrollable list of service locations already known to the system. Or type in the name of the service location; if it does not match any entry on the list, you will be prompted for permission to add the name to the service location data base.

Remarks: Use this field for narrative remarks pertinent to this patient's billing. If you check the **Print remarks** box, these comments will be printed at the foot of the patient's bill; the default is not to print them.

Balances transferred box: You may transfer in balances due from the patient and from insurance on services rendered prior to the indicated as-of date. When you select an as-of date, you must be careful not to subsequently post any visits or payments occurring prior to this date, as these amounts are already incorporated into the starting balances. On the other hand, payments received after the as-of date, even if on account of services rendered prior to the as-of date, should be posted as they will be applied against the opening balance(s).

Patient demographics: part 4

P

Purpose: *Record and display additional patient identifying data*

NB: this window is illustrated under Billing Format Options (page 49, above).

Include in monthly billing run: this item defaults to Yes (checked) but in certain rare situations should be set to No (unchecked). The best example is a patient, such as a victim of domestic violence, whose safety might be endangered if a bill were sent to her home.

Clinician's tax ID no: this item defaults to Yes (checked), and must be included if your statements are to be used as Superbills, i.e. attached to insurance claim forms and submitted for insurance reimbursement. Therefore, it should only be unchecked in pure self-pay situations.

Diagnosis code: defaults to Yes (checked). See remarks above under tax ID no.

Diagnosis text: defaults to No (unchecked). Clinical practice varies on this point, with some clinicians considering the clinical labels unproductive and frightening to patients, while others deem it ethically necessary to share such information with patients.

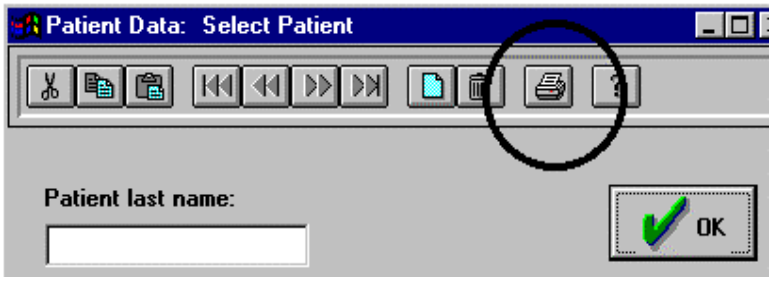
Dunning messages: defaults to Yes (checked), but situations may arise in which you choose to omit the messages on certain patients while including them for others.

Patient/insurance responsibility breakout: check this option for all managed-care patients, uncheck it for self-pay patients and patients with indemnity coverage on which you do not take assignment.

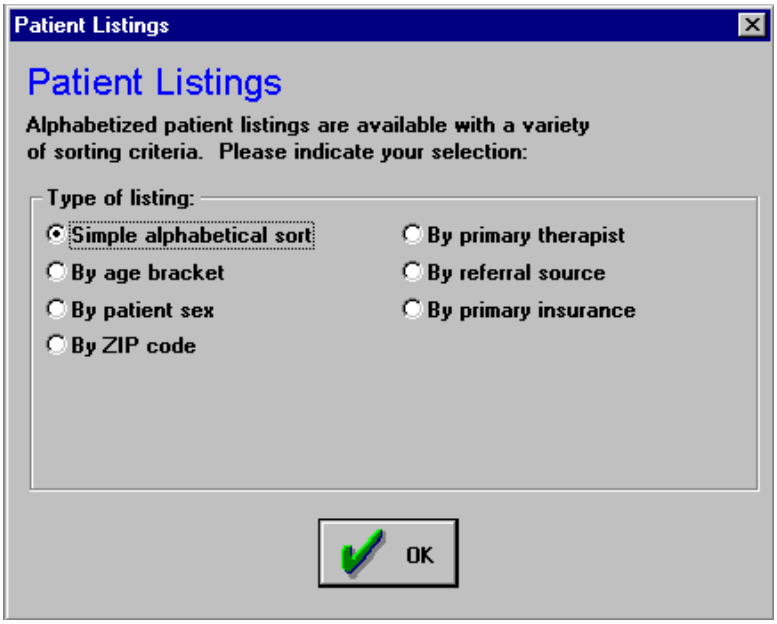
This window also contains three **Fee Override** fields.

These allow you to specify one to three specific services and individually negotiated fees which will be used for this patient's visits, in place of either your scheduled self-pay fee or the usual fee schedule for this patient's type of coverage.

Patient listings, overview



Clicking the Print button on the Patient Database selection window brings up the Patient Listing window, providing printed alphabetical patient listings, broken down by a variety of criteria, as illustrated below. Available subgrouping criteria are age, clinician, insurance coverage, service location, source of referral, and zip code of residence.



Patient selection window

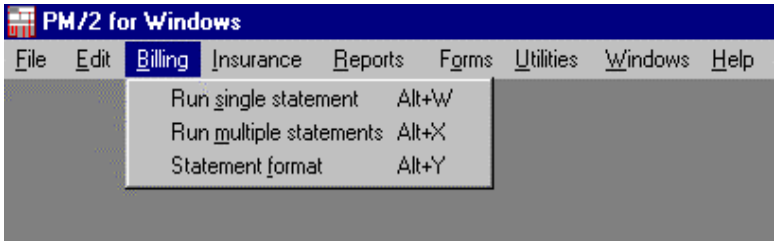
The patient selection window is used for many different functions in PM/2 for Windows where it is necessary to choose a patient record. You can select a patient record in one of two different ways: either

a) Type in the first few characters of the patient's last name. This will make the scrolling list in the lower part of the screen move to the correct section of the alphabetical listing. Verify that the correct patient record is highlighted, and then click OK. Or,

b) Click and drag the scroll bar at the right of the browser, or click and hold the up or down arrows at the ends of the scroll bar, then click OK.

The **arrow** toolbar buttons cause the file pointer to move to the top, previous record, next record and bottom of the file, respectively.

Patient statements, overview

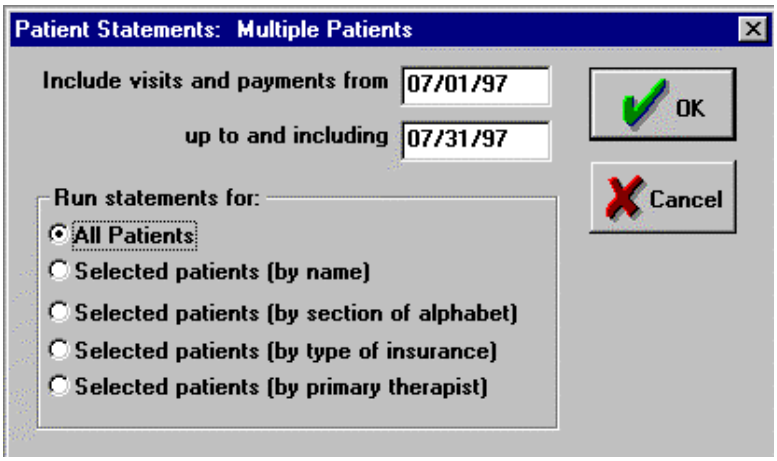


The billing menu produces statements for professional services rendered to the patient over any specified period of time, together with a summary of previous balances and payments and various optional information as specified on the options window.

Patient statements, running multiple

Purpose: *Do a monthly (or other periodic) billing run*
Menu selections: *Billing, Run multiple*
Accelerator key: *Shift + F3*

This menu option enables you to run off statements for all active patients (or a specified subgroup thereof) spanning any desired time interval. The selection window is illustrated below.



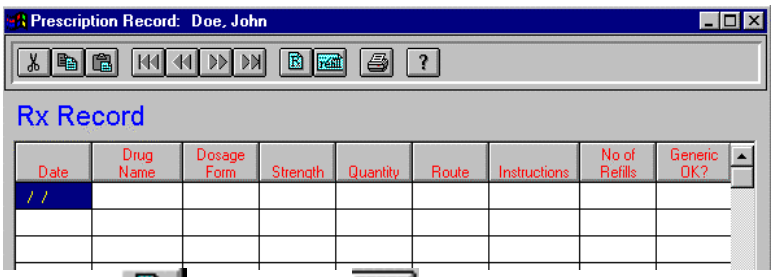
Note the available subgrouping options; the default is "all patients" which means all patients with open account balances and/or account activity in the billing period.

Prescriptions, browsing

Purpose: *Print and record prescriptions for medication*
Menu selections: *File, Clinical, Prescriptions*
Accelerator key: *Ctrl + F9*

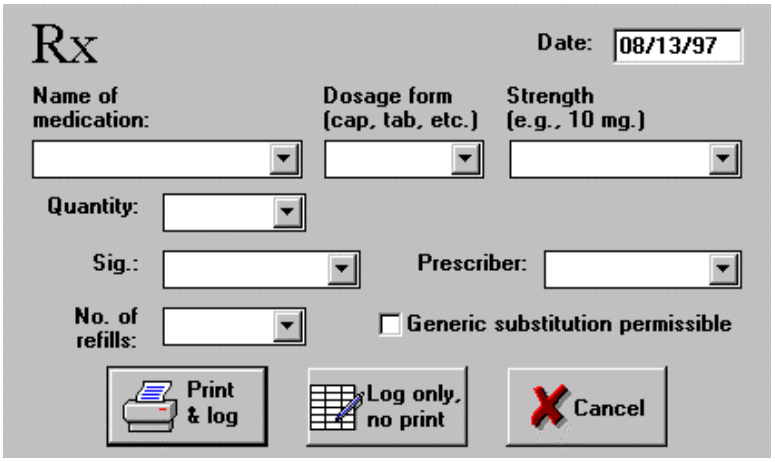
The **Rx Record** window provides a dynamic display of all prescriptions written to date on a given patient. An **Edit Menu** and corresponding **toolbar** are provided for writing new prescriptions, browsing up and down through the prescription record, printing the record out, and activating

this help display.



The **Rx** and **Renew** toolbar buttons are closely related, and will be discussed together.

The **Rx** button brings up the **Prescriptions Writer** template window. This window, illustrated below, contains fields for writing a new prescription. Such new prescriptions can be printed out by the computer and handed to the patient, or the prescriptions can be written by hand, or telephoned in to the pharmacy, and the Prescription Writer used simply for record-keeping purposes.



The Prescription Writer window simulates a printed prescription pad, with fields corresponding to all the data needed to write a traditional prescription.

This window can be used either to produce a written prescription to hand to the patient, or to log prescriptions

which are written by hand or phoned in to the pharmacy.

The **Date** field, by default, contains the current system date.

The next 5 fields are all **combo boxes**, which means that you can either type in the required information, or else click on the down-arrow icon at the right of the field to bring up a list of predetermined options. In the latter case, just click the desired choice to enter it:

- **Medication Name**
- **Dosage Form** (capsule, tablet, etc.)
- **Strength** (typical dosages such as 1 mg, 5 mg, etc.)
- **Sig** (typical instructions such as i bid, ii tid, etc.)
- **Number of refills** (0-9)

The **Generic Substitution Permissible** checkbox causes a statement of generic substitution permissible or not permissible to be printed as a footnote to the prescription. The required language for this statement varies state by state and may not yet been collected for your locality .

At the bottom of the Prescription Writer window are 3 pushbuttons. You normally complete your work with the Prescription Writer by clicking one of these three buttons: **Print and Log** to both print out the prescription and record it in the patient's prescription log; **Log Only** to record it but not print it out, or **Cancel** to abandon the prescription.

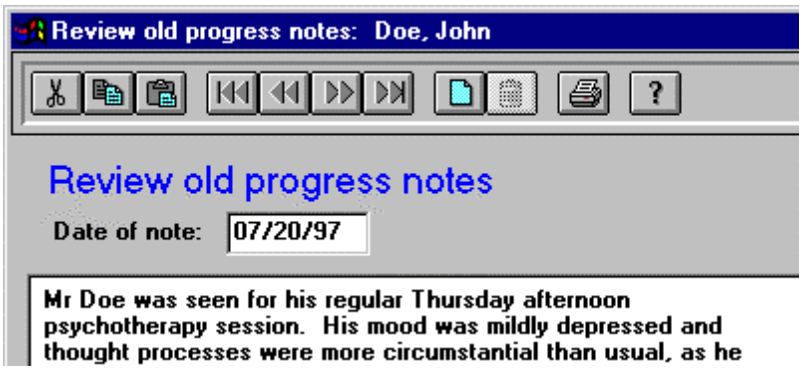
The **Renew** button is a specialized form of the Prescription Writer, in which you first select the prescription from the browse display which you desire to renew, by moving the highlight to that prescription. The Prescription Writer is then brought up, with all fields filled in as per the highlighted prescription except with the current system date replacing the date of the old prescription.

The **Top, Previous, Next** and **Bottom** buttons and Edit Menu options, as usual, move the browse display as their names suggest.

The **Print** button produces a printed Prescription Record containing all the information on the log, in a format appropriate for the printer.

Progress notes

Purpose: *Print and record case notes*
Menu selections: *File, Clinical, Progress notes*
Accelerator key: *Ctrl + F8*

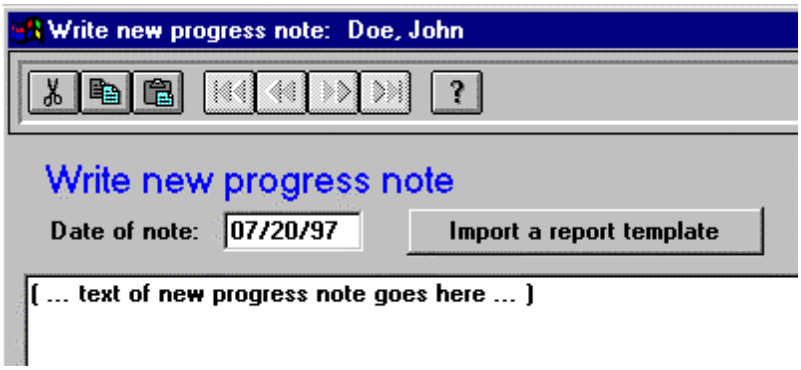

Review old progress notes: Doe, John
Review old progress notes
Date of note:
07/20/97
Mr Doe was seen for his regular Thursday afternoon psychotherapy session. His mood was mildly depressed and thought processes were more circumstantial than usual, as he

When this window is first brought up, it is positioned on the progress note with the latest date. You may move through the file, backwards or forwards in time, by using the toolbar buttons.

Previously written progress notes may not, for obvious medico-legal reasons, be altered or deleted via **PM/2 for Windows**.

To add a new progress note, press the **Insert** toolbar button. To print one, several or all progress notes from a given patient's file, click the **Print** toolbar button,

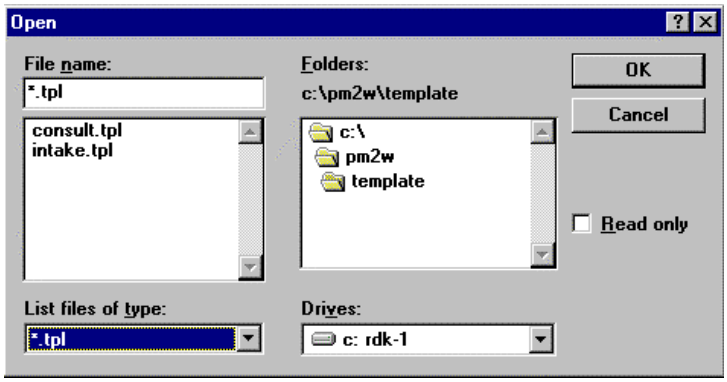
Progress notes, entering new


Write new progress note: Doe, John
Write new progress note
Date of note:
07/20/97
Import a report template
(... text of new progress note goes here ...)

This is the window that comes up when you click the **Insert** button on the Progress Notes Review window (see **Progress notes, reviewing**). It closely resembles the progress notes review window, but this simple window actually provides you with three different ways of adding additional text material to your progress notes file on the given patient:

- **Type in plain text:** Just click the mouse anywhere in the open text area and simply start typing. There is no limitation in practical terms on how long your note can be (the theoretical limit is 64 KB, or approximately 17 single-spaced, typewritten pages).

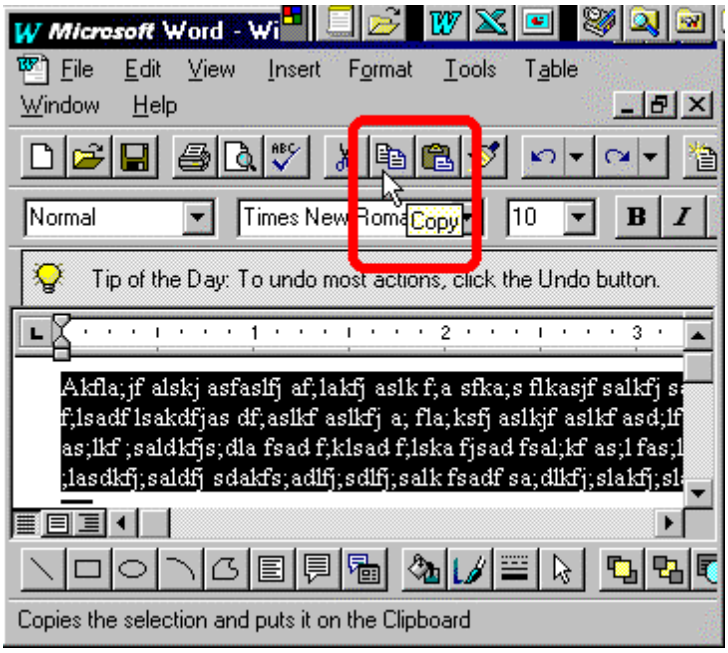
- **Import a document:** Click the **template** button. This brings up the standard File Open Dialog box, which will give you a choice of the opening any of the pre-defined document templates supplied with **PM/2 for Windows**, along with any other templates you may have written on your own:



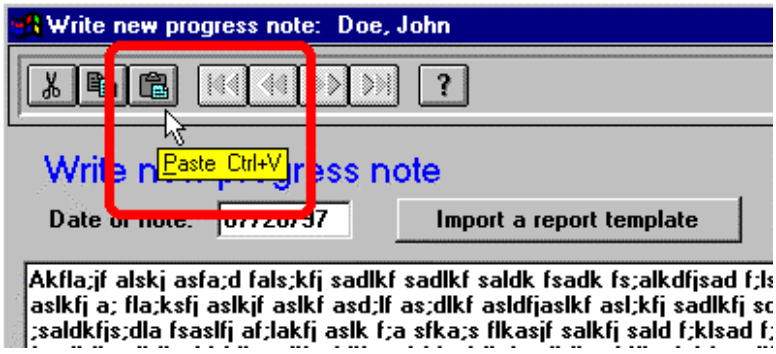
Also, you can go outside the list of template documents by entering the full name of any other file on your computer in the File Name field, or you can browse your entire computer by clicking the folder list at the right. The only restriction is that the document to be imported should be in straight text format, to avoid importing unintelligible word-processor codes. You can get around this problem by using the cut-and-paste approach (see below). Once you have selected your document, its contents will automatically be transferred to the text area of the Enter Progress Notes window.

- **Cut-and-paste:** Open your Windows-based word processor (Word, Wordperfect for Windows, AmiPro, etc.), copy some text to the clipboard, and use the paste button in **PM/2 for Windows** to insert in into the progress notes. The following sequence of screen shots illustrates the process in Microsoft Word:

Highlighting the text in Word:

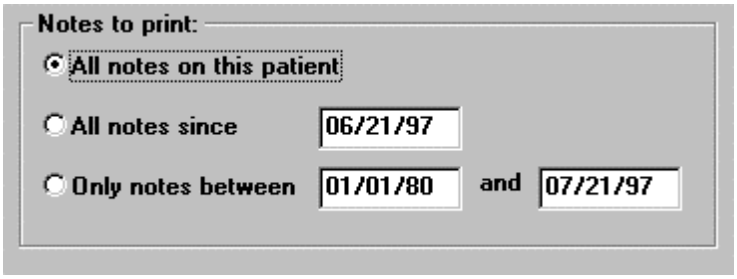

Microsoft Word - Wi
File Edit View Insert Format Tools Table
Window Help
Normal
Times New Roma
Copy
10
Tip of the Day: To undo most actions, click the Undo button.
Copies the selection and puts it on the Clipboard

Click and drag the mouse over the entire desired area of text, then click the Copy button as shown. Then return to PM/2 and paste the text:



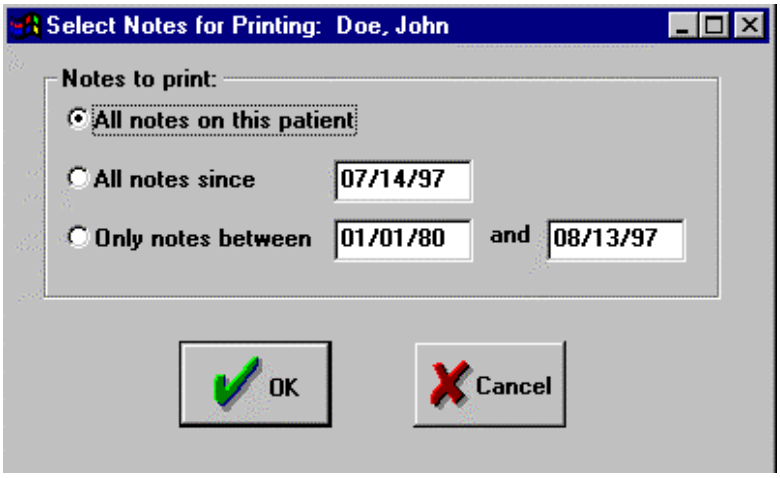
by clicking the Paste button. The pasted text may be kept "as is" or edited as if you had just typed it in manually.

Progress notes, printing of



When you click the **Print** toolbar button on the Review Progress Notes window (see **Progress notes, reviewing)** this window comes up before the notes are printed. It gives you a chance to specify just which notes you wish to have printed out: all notes on the patient, all notes written since a certain date, or only notes written between specific (inclusive) dates. The default is all notes. Click the **OK** button to proceed with the printout, or **Cancel** if you change your mind about the print request.

Progress notes, selecting for printing



When you click the **Print** toolbar button on the Progress Notes browse window, you are given the above illustrated choice of which notes to print: all, all since a given date, or notes between to inclusive given dates

Provider roster

Purpose: *Browse and update the provider data for your practice*
Menu selections: *File, Provider roster*
Accelerator key: *Ctrl + F8*

A standard ***PM/2 for Windows*** browse window, in this case a tabular display of the providers comprising your practice, with all of the data (such as names, license and identification numbers) necessary for patient and insurance billing .

Standard options are also provided for cutting and pasting from the Windows clipboard; moving up and down through

the browse display; adding and deleting entries; and printing the contents of the file.

P

Provider roster, adding new entries

A template for adding new clinicians to the Provider Roster, i.e. when a new practitioner joins your group. Please complete all relevant fields, including EIN **or** SSN but not both.

Click **OK** to confirm the addition to the file or **Cancel** to abandon it.

Provider roster, deleting entries

Deletes the current item from the file. Using with extreme caution as it renders undefined any reference to the item in any other database.

Provider roster, printing

Two different reports (**Summary** and **Detail**) can be selected for printing via this dialog window.

The **Summary Report**, which is the default, is a columnar report listing code number, name, address and telephone number for each provider in your Provider Roster file.

The **Detail Report** is a paragraph-style report which shows all of the above data plus drug registration, license, UPIN, Blue Cross and Medicaid numbers, and up to ten fields of user-defined data, for each provider in your Provider Roster file.

Select the report you desire by clicking the appropriate option, then click the OK button. Or click Cancel to cancel

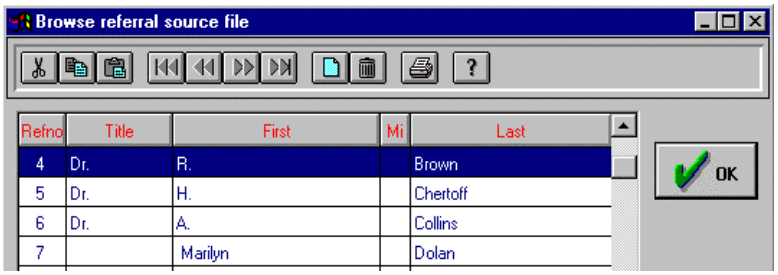
production of the report and return to the Provider Roster browse window.

P

Referral source file

Purpose: *Browse and update the Referral Source file*
Menu selections: *File, Referral sources*
Accelerator key: *F6*

This is a *browse window* displaying, in tabular form, the list of entities (fellow professionals, agencies, present/former patients, etc.) whom you have identified as sources of referrals to your practice:



Standard options are also provided for cutting and pasting from the Windows clipboard; moving up and down through the browse display; adding and deleting entries; and printing the contents of the file.

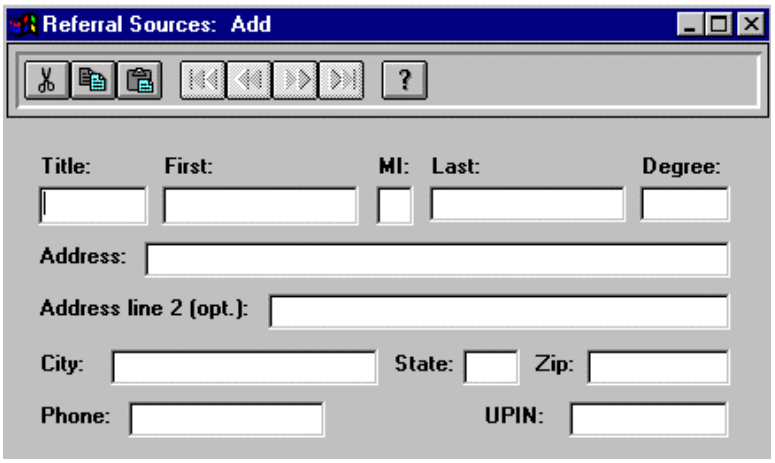
Referral source file, adding new entries

A template for adding new items to the Referral Sources file, activated when you press the **Insert** toolbar button on the referral source browse window.

The **Last Name** field is required; all other fields are optional.

UPIN is the Universal Provider Identification Number,

issued by HCFA and required when you show a referral source on a Medicare claim.



Click **OK** to confirm the addition to the file or **Cancel** to abandon it.

Referral source file, deleting entries

Deletes the current item from the file. Using with extreme caution as it renders undefined any reference to the item in any other database.

Referral source file, printing

Two different reports (**Summary** and **Detail**) can be selected for printing via this dialog window.
The **Summary Report**, which is the default, is a columnar report listing code number, name, address and telephone number for each source in your Referral Source file.

Type of report desired
Please indicate type of report desired:
Summary report (one line per record)
Detail report (all data on each record)
OK
Cancel

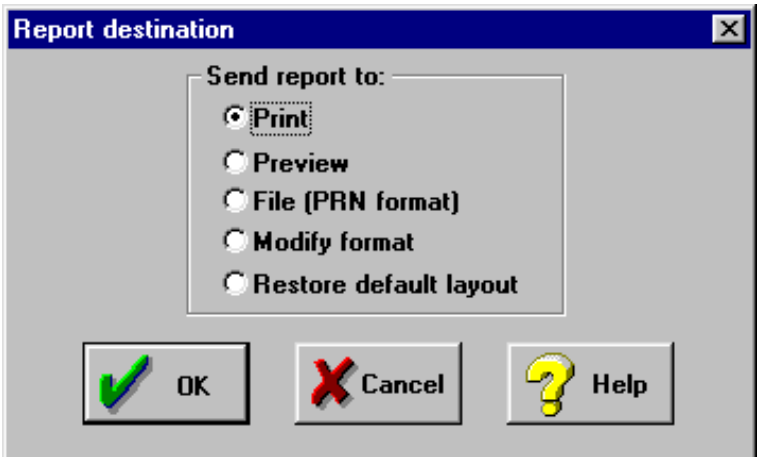
The **Detail Report** is a paragraph-style report which shows all of the above data plus drug registration, license, UPIN, Blue Cross and Medicaid numbers, and up to ten fields of user-defined data, for each source in your Referral source file.

Select the report you desire by clicking the appropriate option, then click the OK button. Or click Cancel to cancel production of the report and return to the Referral source file browse window.

The Summary Report for this heading lists the data one line per record. Some fields are omitted for reasons of space.

The Detail report presents the data in paragraph form, with no fields omitted. If your database is large, we suggest using the Preview feature before printing, for the Detail reports get quite lengthy.

Report Destination window



Use this window to tell the system where to send the output from your report request. This information is used by PM/2's ReportPro engine in setting up your report.

Print: Make sure your printer is ready and loaded with the appropriate type of paper before you select this option, which sends the output directly to the printer. If you are printing an insurance claim on preprinted forms, for example, make sure that the printer is loaded with these forms before clicking OK.

Preview: This option sends the output to a special Preview window so that you can view it before deciding whether to print it out on paper. The preview window has a button that enables Preview output to then be sent to the printer, if desired.

File, PRN format: This option sends the output to a disk file, preserving all of its formatting codes (e.g. font selections). A dialog box comes up with a proposed file name for the report file, which can then be copied to the printer at a later time. This option is convenient if you are using PM/2 on a laptop computer that is not connected to a printer at the time you are running a report.

Modify format: Instead of sending your report to an output device, this option brings up a special formatting screen that allows you to modify the layout and content of any PM/2 report. A special dedicated Help system is available by clicking the Help option within the Modify Format window.

Restore default layout: If you decide that you don't want to keep the changes you have made, click this option to restore the original layout even if you haven't made an explicit backup.

Restoring your databases from backups

Purpose: *Bring back "lost" data files or undo erroneous data entry*
Menu selections: *Utilities, Restore*
Accelerator key: *Shift + Alt + F2*

This is a disaster-recovery option. If you have good backup diskettes and your databases have been lost, corrupted or destroyed but you can still open PM/2 for Windows, click Utilities, Restore to bring up this window:

Restore data files from backup copy
WARNING: Restoring from backup will replace your existing data files. Continue?
OK
Cancel

On most installations, your diskette drive will be the default "a:" and your destination directory will be the default C:\PM2W\DATA.

If you are unable to start PM/2 for Windows at all, then you

will need to re-install the product from the original diskettes and then use this option to bring back your data files.

R

Service locations file

Purpose: *Browse and update the Place of Service file*
Menu selections: *File, Service Locations*
Accelerator key: *Ctrl + F7*

A file virtually identical in structure and operation to that described above for Referral Sources. Please refer to the Referral Sources section for a full description of this file. The only unique field in this browser is the location type (LOCTYPE) field, which is a code set by HCFA to describe the service location: e.g., all private offices are type 11, all inpatient hospital settings are type 21, etc.

Statement format

See **billing format**, above.

S

Toolbar buttons

Toolbar buttons are small icons placed at the top of a window. They are graphical shortcuts for menu options and have the identical functionality (do the exact same thing as) the menu options to which they are related. Most users find it more convenient to use the toolbar buttons, when available, rather than the menus, because they require fewer mouse clicks and are always visible.

When toolbar buttons are dimmed, it is because the corresponding menu options are unavailable on the particular window that has focus. For example, the record-movement (top / previous / next / bottom) options:

are not available when viewing the Patient Demographics window.

Click the Cut button to remove the highlighted text from its source, and save it to the Clipboard for possible insertion elsewhere in the same or another application.

Click the Copy button to copy the highlighted text from its source to the Clipboard for possible insertion elsewhere in the same or another application. Copy is different from Cut in that it does not remove the text from its original location.

Click the Paste button to copy the text, which was placed on the Clipboard by a previous Cut or Copy command, into a text field on a window. A copy of the text remains on the Clipboard for possible re-use elsewhere, until displaced by the next Cut or Copy operation.

Clicking the **Print** toolbar button (or the corresponding option on the Edit menu) results in a printout of the file displayed in the window. In the case of a browse window, this will be a listing of all the records visible via the browse, not just the ones visible on screen at the time the button is clicked. In the case of a "form view" window (i.e., one that shows detailed information about a single case, such as a Patient Demographics window) the Print button produces a printout of data on the particular case on view.

These four toolbar buttons are enabled on all windows which provide a "browse view" of a database, that is, a tabular view of all or some of the records in a database which can be scrolled up and down. Patterned after the buttons on an audio or video CD or tape player, these buttons move the record pointer respectively to the top of the file, to the record just above the current record (the "previous" record), to the next record in the file, and to the bottom of the file.

Transfers, posting of

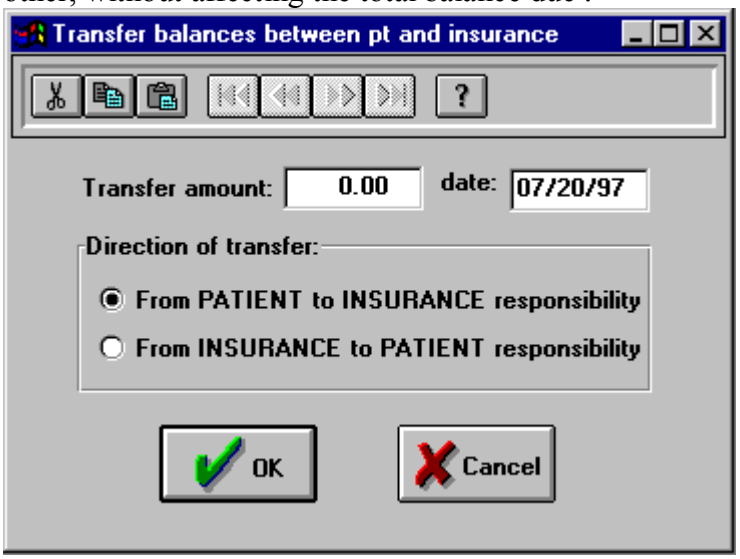
T

Purpose: *Shift amounts due between Patient and Insurance responsibility*
Menu selections: *Posting, Transfers*
Accelerator key: *None*

There may be times when amounts shown on the bottom line of the Patient Account Record as being due from the patient, will need to be changed to insurance responsibility, or vice versa:

In such situations, use this Balance Transfer window (see below) to move such amounts from one column to the

other, without affecting the total balance due .



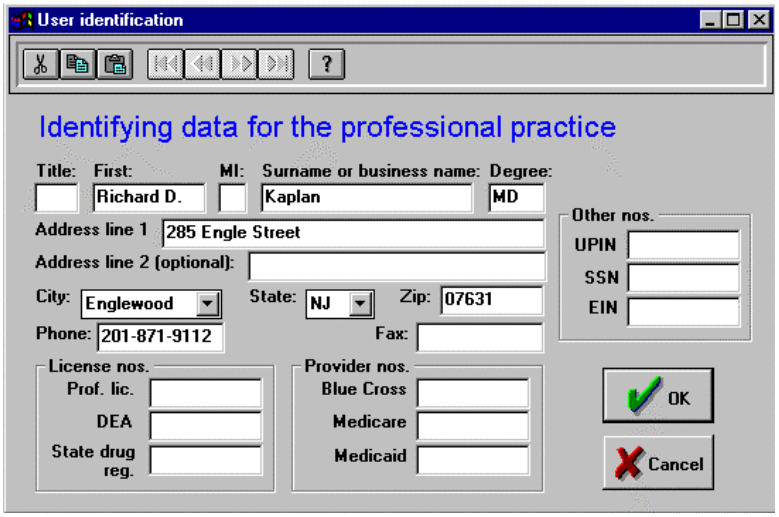
Treatment planning menu

This menu option activates PM/2 Clinical Planner, an optional feature of PM/2. See the separately printed Clinical Planner documentation for details. If you have not purchased the PM/2 Clinical Planner option, a demo version of PM/2 may be available on your system, which can be upgraded to the licensed version at any time upon payment of the license fee.

U

User identification window

Purpose: *Record basic identifying data on the practice*
Menu selections: *File, User identification*
Accelerator key: *F2*



Single-practitioner installations: This is the window for entering the practitioner's name, address, insurance identification nos., and other billing information.

Multiple-practitioner installations: This is the window for entering details about the practice as a whole, as opposed to details about the individual practitioners which gets listed on the Provider Roster. Leave blank those fields, such as individual license nos., which do not apply to the practice as a whole.

U

Appendix A: Electronic claims submission

In addition to HCFA-1500 forms, PM/2 for Windows can output your claims data to disk files according to National Standard Format (NSF) version 2.0. These claim files can be set up according to exactly the same criteria as a paper claims run, i.e., for all patients, or a defined subgroup of patients, for any period of time selected by the user.

Once the claims file has been produced, it can be sent either to one of our designated clearing houses, or directly to the end payor if you prefer. We strongly encourage the use of one of our contracted clearing houses because there is an unfortunate lack of uniformity in implementation of the NSF, so that we can only guarantee that our NSF files will be fully compatible with the requirements of our clearing houses.

Prior to any electronic submission, you must sign up with the clearing house or the end payor in order to be recognized as an electronic submitter. Please contact our office for the required signup forms if you have not already received them. You must receive a User ID code directly from the clearing house before attempting any transmission.

Here is a summary protocol for electronic submission to our primary clearing house, Envoy-NEIC, once you have received their approval for sending through a test submission:

A. **Build your claims file** by clicking Insurance, Electronic Claims Submission, Run Claims. Enter your start and end service dates, then click OK. Wait for the complete claims file to appear in the display window. Make a note of the file name as prompted in the message box.

B. **Transmit your claims file** by clicking Transmit Now at the bottom of the claims window. This button will launch

Hyperterminal, the built-in Windows communication package. The following 6 steps are required:

1. Click the "Envoy" icon within the Hyperterminal main window. This will cause your modem to dial Envoy's number.

2. When you receive the prompt "Login", type in **Kermit** and press [Enter].

3. When you recieve the prompt "Password", type in **Uniclaim** and press [Enter]

4. Ignore the paragraph or so of text which follows. Then, from the Hyperterminal menu at the top of the window, select Transfer, Send File.

5. In the Send window, enter **c:\mgr\signon.son** as the file name, and **Kermit** as the Protocol. Then click the Send button. The signon.son file is very short, so that the transmission is almost instantaneous; if you blink, you may miss the window that confirms that the file has been sent!

6. Now you are ready to send the claims file. If, for example, the claims file is called NS0004.TST (it will have a different name each time you build one), then you would again activate the Send window, this time entering **c:\mgr\ns0004.tst** as the file name. The protocol is again **kermit.** Then click Send. This time, the transmission will take a minute or two and you'll be able to watch its progress on the window.

C. **Receive your audit/edit reports:** this is also a 6-step procedure. Wait about an hour after transmitting your claims, then repeat steps B1-B4 above. On step 5, substitute **getmail.son** for signon.son. On step 6, click Transfer and then **Receive** instead of Send. No file names need to be specified; the Envoy system will automatically send you whatever reports happen to be waiting for you in

your mailbox. You can download these reports to any folder (directory), then using Windows Explorer double-click each report and view and/or print it using Notepador Wordpad.

APPENDIX

Appendix B: User-designed reports

This is an advanced topic, actually meriting a book in itself. In this Appendix, we can only point in a general way at the approach to designing your own reports in PM/2 for Windows.

There are two approaches to designing your own reports in PM/2 for Windows. Users who have not previously worked with a Windows report generator would do well to start with one of the simpler built-in reports, such as the Activity reports (Cash Journal or Patient Contact). Run one of these reports, but when the Report Destination window comes up, click Modify Format instead of Print or Preview. This will bring up the template for the report. Some aspects of the template will be immediately evident, even if the details are not obvious: the report is divided into sections, including a heading, a body, and a footer. The heading includes a title and a label for each column of the report. The body section is repeated once for each line item in the report, and contains the actual specifications for each data item (as opposed to the text labels in the heading section). Footers usually contain totals or explanatory statements. The report may also contain grouping or subtotal specifications. Experiment with selecting (by mouse clicks), moving (by drop-and-drag), editing, deleting and adding items to the selected report. There is an extensive specialized on-line Help system which is activated only when you are working on the template grid; make liberal use of it!

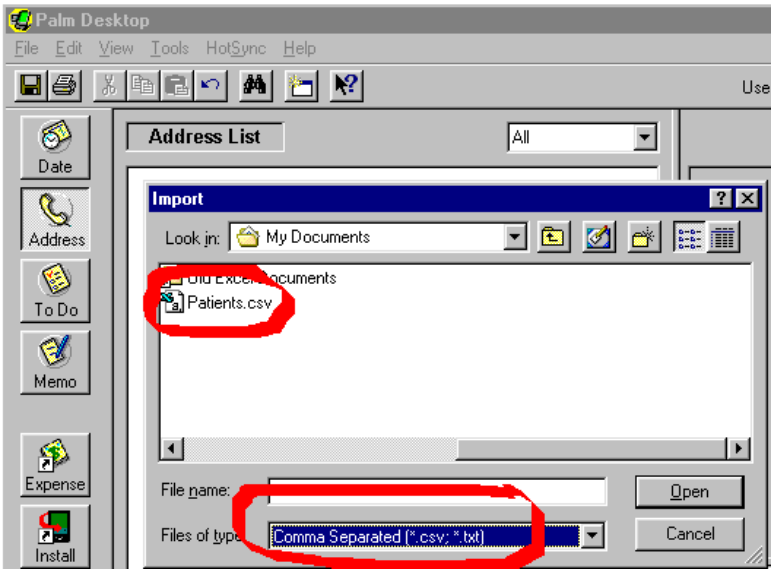
More experienced users may wish to design reports that are entirely original. In this case, start by clicking Reports, User-designed reports, Create new report, and follow the report wizard through the required steps. Please note that all field names in PM/2 for Windows are essentially self-explanatory, e.g., **`Patients.first`** means the patient's first name; **`doc.add1`** means the first line of the provider's office address, etc. A complete list of field definitions is included in Appendix D.

Please note also that when you modify one of the built-in report formats, your modified version becomes the system's new standard (default) template for that report. However, you can experiment without undue anxiety because the original version is automatically saved by the system, and you can revert to the original at any time by clicking the "restore default" option in the Report Destination window.

Appendix C: Exporting data to the Palm Pilot

PM/2 now offers the ability to export your Patient Data Base to your Palm Pilot desktop. Simply click Utilities, Export to Palm Pilot Format and the system automatically sends a file called **PATIENTS.CSV** to the My Documents folder. This file can be read directly into the Palm Desktop's Address Book by clicking File, Import and selecting PATIENTS.CSV from the default file list. Accept all of the import defaults, then place your Palm Pilot in its cradle and press the HotSync button to copy the new information into the handheld device. It's that simple! And the process can be repeated as often as you wish, to bring in updated versions of your patient list.

Here is a view of the Import window of the Palm Desktop, with the critical areas highlighted:



Note the file name, patients.csv, which will pop right into view after you select the "comma-separated values" option at the bottom of the window. Just highlight patients.csv and click Open to complete the import.

APPENDIX

Appendix D: Databases and Data Field Names

APPENDIX

```
city.cityname

tier.text1
tier.nvis
tier.cpt4
tier.text2
tier.copayamt
tier.copaypct

adjust.pt_no
adjust.post_date
adjust.adj_date
adjust.categ
adjust.insco
adjust.amount
adjust.remarks

chmpbrn.brn_code
chmpbrn.brn_text
chmpgrd.spon_code
chmpgrd.spon_text
chmpnavl.navlcode
chmpnavl.navltext
chmpstat.stat_code
chmpstat.stat_text

copay.no
copay.eff_date
copay.deductible
copay.copay1
copay.nvis1
copay.copay2
copay.nvis2
copay.copay3
copay.nvis3
copay.dollarcap
copay.nvis4
copay.copay4
copay.visittype1
copay.visittype2
copay.visittype3
copay.visittype4
copay.copaytype

daysheet.svcdate
daysheet.ptname
daysheet.pt_no
daysheet.svctype
daysheet.docno
daysheet.locno
daysheet.ckno
daysheet.chg_amt
daysheet.cred_amt
daysheet.posted
daysheet.remarks
daysheet.descrip
daysheet.docname
daysheet.locname
daysheet.categ
daysheet.con_charge

doc.docno
doc.title
doc.first
doc.mi
doc.last
doc.degree
doc.add1
doc.add2
doc.city
doc.state
doc.zip
doc.phone
doc.fax
doc.ssn
doc.ein
doc.license
doc.dea
doc.statedrug
doc.upin
doc.billunder
doc.bluecross
doc.medicare
doc.medicaid
doc.specialty
doc.user1
doc.user2
doc.user3
doc.user4
doc.user5
doc.user6
doc.user7
doc.user8
doc.user9
doc.user10

drugs.brandname
drugs.form
drugs.strength
drugs.category
drugs.generic

dsm.dxcode
dsm.dxname

guar.last
guar.first
guar.mi
guar.suffix
guar.title
guar.no
guar.add1
guar.add2
guar.city
guar.zip
guar.state
guar.hometel
guar.offtel
guar.celltel
guar.pager
guar.pharmtel
guar.othertel
guar.ssn
guar.sex
guar.dob
guar.remarks
guar.seq
guar.relation

icd.dxcode
icd.dxname

insco.inscono
insco.name
insco.add1
insco.add2
insco.city
insco.state
insco.zip
insco.claimsrep
insco.hmo
insco.phone
insco.idno
insco.format
insco.feesched
insco.instype
insco.print_flag

insured.no
insured.seq
insured.title
insured.first
insured.mi
insured.suffix
insured.last
insured.add1
insured.add2
insured.hometel
insured.offtel
insured.ssn
insured.sex
insured.dob
insured.city
insured.state
insured.zip
insured.carrier
insured.idno
insured.groupname
insured.groupno
insured.signature1
insured.signature2
insured.employer
insured.emplyradd1
insured.emplyradd2
```

```
insured.champbrnch
insured.champnonav
insured.champgrade
insured.champstats
insured.sig1date
insured.sig2date
insured.reln
insured.eff_date
insured.deductible
insured.copay1
insured.nvis1
insured.visittype1
insured.doc1
insured.copay2
insured.nvis2
insured.visittype2
insured.doc2
insured.copay3
insured.nvis3
insured.visittype3
insured.doc3
insured.copay4
insured.nvis4
insured.visittype4
insured.doc4
insured.dollarcap
insured.copaytype
insured.copaypct1
insured.copaypct2
insured.copaypct3
insured.copaypct4
insured.sigsource
insured.assignment

lab.pt_no
lab.lab_date
lab.value
lab.hi
lab.lo
lab.test_name

loc.locno
loc.name
loc.add1
loc.add2
loc.city
loc.state
loc.zip
loc.phone
loc.loctype
loc.idno
loc.user1
loc.user2
loc.user3
loc.user4
loc.user5
loc.user6
loc.user7
loc.user8
loc.user9
loc.user10

mgdcare.pt_no
mgdcare.auth_date
mgdcare.auth_no
mgdcare.exp_date
mgdcare.docno
mgdcare.svctype
mgdcare.nvis

options.bf_taxid
options.bf_dxcode
options.bf_dxtxt
options.bf_dun
options.bf_info
options.bf_infotxt
options.bf_int
options.bf_break
options.bf_dun1
options.bf_dun2
options.bf_dun3
options.bf_dun4
options.bf_font
options.bf_wrap

password.password
password.userid
password.level
password.docno

patients.last
patients.first
patients.mi
patients.suffix
patients.title
patients.pt_no
patients.add1
patients.add2
patients.city
patients.zip
patients.state
patients.hometel
patients.offtel
patients.celltel
patients.pager
patients.pharmtel
patients.othertel
patients.ssn
patients.remarks
patients.sex
patients.dob
patients.rx
patients.dx1
patients.dx2
patients.dx3
patients.svc1
patients.svc2
patients.svc3
patients.fee1
patients.fee2
patients.fee3
patients.docno
patients.locno
patients.refno
patients.is_icd
patients.copayno
patients.onset_date
patients.sim_date
patients.ad_date
patients.dischdate
patients.startdisab
patients.enddisab
patients.tp_date
patients.death_date
patients.epsdt
patients.famplan
patients.emerg
patients.empl_rel
patients.autoacc
patients.autoaccst
patients.otheracc
patients.asofdate
patients.patbal
patients.insbal
patients.printrem
patients.include1
patients.include2
patients.include3
patients.include4
patients.include5
patients.include6
patients.include7
patients.include8
patients.decade
patients.archive
patients.marital
patients.empstat
patients.select
patients.pttot
patients.instot
patients.user01
patients.user02
patients.user03
patients.user04
patients.user05
patients.user06
patients.user07
patients.user08
patients.user09
patients.user10

payments.pt_no
payments.pmt_date
payments.post_date
payments.categ
payments.insco
payments.amount
payments.remarks
payments.svctype
payments.locno
payments.type
payments.docno

prognote.pt_no
prognote.notes
prognote.notedate

ref.refno
ref.title
```

```
ref.first
ref.mi
ref.last
ref.degree
ref.add1
ref.add2
ref.city
ref.state
ref.zip
ref.phone
ref.upin
ref.user1
ref.user2
ref.user3
ref.user4
ref.user5
ref.user6
ref.user7
ref.user8
ref.user9
ref.user10

relation.rel_code
relation.rel_text

rx.pt_no
rx.rxdate
rx.drugname
rx.form
rx.strength
rx.dispense
rx.route
rx.freq
rx.refill
rx.generic

services.categ
services.svctype
services.medcare
services.descrip
services.cash
services.cred_deb
services.cpt4
services.units
services.tos
services.price
services.mod1
services.mod2
services.price1
services.price2
services.price3
services.price4
services.price5
services.price6
services.price7
services.price8
services.price9

state.state
state.state_text

tests.test_name
tests.hi
tests.lo
transact.svcdate
transact.postdate
transact.pt_no
transact.svctype
transact.docno
transact.locno
transact.nom_charge
transact.mcwriteoff
transact.con_charge
transact.copay
transact.ded
transact.overlim
transact.adj
transact.pt_resp
transact.pt_pd
transact.pt_bal
transact.withhold
transact.ins_resp
transact.ins1_pd
transact.ins2_pd
transact.ins_bal
transact.bal
transact.dx
transact.ckno
transact.remarks
transact.page
transact.extra
transact.appl_dedct

userid.title
userid.first
userid.mi
userid.last
userid.degree
userid.add1
userid.add2
userid.city
userid.state
userid.zip
userid.phone
userid.fax
userid.ssn
userid.ein
userid.license
userid.dea
userid.statedrug
userid.upin
userid.billunder
userid.bluecross
userid.medicare
userid.medicaid
userid.user1
userid.user2
userid.user3
userid.user4
userid.user5
userid.user6
userid.user7
userid.user8
userid.user9
userid.user10
visit.pt_no
visit.svcdate
visit.descrip
visit.location
visit.charge
visit.ptpay
visit.ins1pay
visit.ins2pay
visit.adjust
visit.riskpool
visit.bal
visit.pt_est
visit.ins_est

zip.cityname
zip.zipcode
zip.state

sunday.weekof

calendar.docno
calendar.weekof
calendar.rec
calendar.line
calendar.time
calendar.descrip
calendar.sun
calendar.mon
calendar.tue
calendar.wed
calendar.thu
calendar.fri
calendar.sat
calendar.sun_no
calendar.mon_no
calendar.tue_no
calendar.wed_no
calendar.thu_no
calendar.fri_no
calendar.sat_no
```

APPENDIX

Appendix E: HCFA policy on acceptability of computer-generated vs. pre-printed (red) HCFA-1500 forms for Medicare claims

The following information is taken directly from HCFA's web site at http://www.hcfa.gov/medicare/edi/1500info.htm as of 21 March 2000. Please check this website periodically for the possible updates of this information.

"If you intend to make paper copies of … Form HCFA-1500 … for claims submission purposes, please ***contact the specific health care payer that you intend to submit these claims to before submitting these claims for payment.*** *Some payers may be able to accept a black & white copy of Form HCFA-1500. Other payers may not accept a black & white copy if they are utilizing Optical Character Recognition (OCR) equipment.*

"If a Medicare carrier utilizes Optical Character Recognition (OCR) equipment to process Form HCFA-1500s, then the provider or supplier must submit these forms using the scannable, red ink version of Form HCFA-1500. These red ink versions of Form HCFA-1500 can be purchased from a printer company, such as the U.S. Government Printing Office at 202-512-1800, or your local Medicare carrier. Please note that the red ink used to print Form HCFA-1500 (i.e., exact ink is Sinclair Valentine J6983, OCR Red or Equal) can not be duplicated by your PC printer. Therefore, if you attempt to print red-ink versions of Form HCFA-1500 from your PC printer, our Medicare carriers will not be able to process your claim.

"Good News: *There are some Medicare carriers that will accept 'black & white' copies of Form HCFA-1500.*

"If a Medicare carrier is not currently utilizing OCR equipment to process claims, they ***may*** *accept Form HCFA-1500 facsimiles that are generated by dot matrix or laser jet printers as long as the originals are submitted for payment.*

"If a Medicare carrier accepts 'black & white' copies of Form HCFA-1500, the back side of the form does not have to be printed and submitted with each claim if the provider or supplier files with their Medicare carrier a signed statement indicating that he or she has read the reverse side of Form HCFA-1500, understands the requirements and agrees to comply with applicable Medicare billing requirements. This statement must be filed by the provider or supplier and sent to the carrier on an annual basis.

"Please note though that if a Medicare carrier is not currently utilizing OCR equipment, but decides to use it in the future, the Medicare carrier may require providers and suppliers at that time to submit Form HCFA-1500s using OCR processable forms.

"Please contact your local Medicare carrier and ask them whether or not they accept 'black & white' copies of Form HCFA-1500. To assist you, some of our carriers have provided us with this information below. If they do accept 'black & white' copies, ask them for details regarding the certification statement. If you do not know the phone number of your local Medicare carrier, go to http://www.hcfa.gov/regions/default.htm and click on the state you reside in."

State	Carriers	Accept B&W?	Notes
Arkansas	BC/BS of ARK and LA	Yes	As long as it is legible and both sides of form are copied on a single double sided sheet of paper.
California	Transamerica Occidental	No	
	National Heritage Insurance Company (NHIC)	No	
Connecticut	United Health Care - CT	No	
Delaware	BC/BS of Texas	Yes	Ink must be dark enough to microfilm.
Florida	BC/BS of Florida	No	Will Accept "Black & White" Form for Flu Roster Bills.
Georgia	BC/BS of Georgia	No	
Idaho	CIGNA	No	
Kentucky	BC/BS of Kentucky	Yes	As long as it is legible and both sides of form are copied on a single double sided sheet of paper.
Louisiana	BC/BS of ARK and LA	Yes	As long as it is legible and both sides of form are copied on a single double sided sheet of paper.
Maine	National Heritage Insurance Company (NHIC)	No	
Maryland	BC/BS of Texas	Yes	Ink must be dark enough to microfilm.
Massachusetts	National Heritage Insurance Company (NHIC)	No	
Minnesota	United Health Care - MN	No	
New Hampshire	National Heritage Insurance Company (NHIC)	No	
New Mexico	BC/BS of ARK & LA	Yes	As long as it is legible and both sides of form are copied on a single double sided sheet of paper.
New York	BC/BS of WNY	Yes	As long as it is legible and both sides of form are copied on a single double sided sheet of paper.
	Empire Medicare Services	No	

	Group Health Incorporated (GHI)	No	Will sometimes accept under certain circumstances. Please call for details.
	Triple S	Yes	
North Carolina	CIGNA	No	
Oklahoma	BC/BS of ARK & LA	Yes	As long as it is legible and both sides of form are copied on a single double sided sheet of paper.
Pennsylvania	XACT Medicare Services	No	
Rhode Island	BC/BS of Rhode Island	No	
Tennessee	CIGNA	No	
Texas	BC/BS of Texas	No	
Vermont	National Heritage Insurance Company (NHIC)	No	
Virginia	United Health Care - VA	No	
Washington D.C.	BC/BS of Texas	Yes	Ink must be dark enough to microfilm.

APPENDIX

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